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Supreme Court, U.S.
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No. 00-___

IN THE

Supreme Court of the United States

Community Health Partners, Inc., and
Reservoir Park Health Services, Inc.,
doing business as Center Care,
Petitioners,

v.

Commonwealth of Kentucky and
Janie A. Miller, Commissioner of Insurance,
Respondents.

On Petition for a Writ of Certiorari
to the United States Court of Appeals
for the Sixth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Twenty-four states have adopted "Any Willing Provider" ("AWP") statutes requiring health care plans to admit any provider willing to abide by the plans' terms. A divided panel of the Sixth Circuit in this case (adopting the reasoning of the Fourth Circuit) held that AWP statutes "regulate insurance" and therefore are saved from preemption by ERISA. The Fifth and Eighth Circuits have reached the opposite conclusion, invalidating the AWP statutes of Arkansas, Louisiana, and Texas. Those circuits rely on this Court's square holding that agreements between insurers and third-party providers do *not* constitute the business of insurance. *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205 (1979). In total, the AWP statutes of nine states have been challenged on ERISA preemption grounds in at least fourteen lawsuits, with a majority having been invalidated.

The Question Presented is:

Whether state Any Willing Provider statutes are preempted by ERISA?

PARTIES TO THE PROCEEDINGS BELOW

All the parties to the proceedings below are named in the caption, except that respondent Janie A. Miller succeeded to the position of the Commissioner of Insurance of the Commonwealth of Kentucky after the court of appeals issued its opinion. Respondent Miller is accordingly substituted pursuant to this Court's Rule 35.3.

RULE 29.6 STATEMENT

Petitioner Community Health Plans is controlled by Commonwealth Health Corporation and Gilbert, Barbee, Moore, & McElroy, P.S.C. Commonwealth Health Corporation is also the parent corporation of petitioner Reservoir Park Health Services. No publicly held company owns 10% or more of either petitioner's stock.

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PETITION FOR A WRIT OF CERTIORARI

Petitioners Community Health Partners, Inc., and Reservoir Park Health Services, Inc., respectfully petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Sixth Circuit in this case.

OPINIONS BELOW

The Sixth Circuit's opinion (Pet. App. 1a-3a) incorporates its opinion in a companion case, *Kentucky Ass'n of Health Plans* v. *Nichols* (Pet. App. 32a-93a) (per Holshuh, Senior D.J. (sitting by designation), joined by Norris, J., with Kennedy, J., dissenting), which is published at 227 F.3d 352 (2000). The court of appeals' order denying rehearing and rehearing en banc (Pet. App. 31a) is unpublished. The district court's opinion (per McKinley, D.J.) (Pet. App. 4a-30a) is published at 14 F. Supp. 2d 991 (W.D. Ky. 1998).

RELEVANT STATUTORY PROVISIONS

This case presents the question whether state "Any Willing Provider" statutes "regulate insurance" and therefore are saved from preemption under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.* The relevant provisions of the Kentucky Any Willing Provider statute and ERISA are reprinted in the appendix (Pet. App. 103a-106a).

JURISDICTION

The court of appeals issued its opinion on September 12, 2000, and denied petitioners' timely petition for rehearing and suggestion of rehearing en banc on November 13, 2000. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

STATEMENT

This case presents one of the most pressing legal questions in health care today: whether states can prohibit managed care organizations such as group health plans and health maintenance organizations ("HMOs") from maintaining se-

lective networks of health care providers. Nearly half the states have enacted "Any Willing Provider" ("AWP") statutes, applicable to all or some subset of health care, requiring health benefit plans to admit all providers who agree to abide by the plans' terms.[1] AWP statutes do not regulate an insurer's relationships with its policyholders – *e.g.*, by regulating the type of the plan, the conditions covered, or the policyholders' premiums and deductibles. Nor do they directly regulate the insurer itself, as by setting minimum financial reserve requirements. Instead, they regulate the relationship between an insurer and its third-party providers. The question whether AWP statutes nonetheless "regulate insurance" so as to be saved from ERISA preemption, see 29 U.S.C. § 1144(b)(2)(A), has vexed the lower courts and is of vital importance to the future of health care delivery in America.

In this case, a divided panel of the Sixth Circuit held that although AWP statutes "relate to" ERISA plans and would therefore ordinarily be preempted, see 29 U.S.C. § 1144(a), they are saved from preemption because they regulate insurance, see *id.* § 1144(b)(2)(A). That decision conflicts with this Court's precedents interpreting ERISA's savings clause,

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[1] See Ala. Code § 27-45-3; Ark. Code Ann. §§ 23-99-204, -303; Conn. Gen. Stat. § 38A-471; Del. Code Ann. tit. 18, § 7303; Ga. Code Ann. §§ 33-20-16, -30-25; Idaho Code §§ 41-2872, -3927(1); Ind. Code Ann. § 27-8-11-3(c); Ky. Rev. Stat. Ann. § 304.17A-270, -171; La. Rev. Stat. Ann. § 40:2202(5)(c); Mass. Ann. Laws ch. 176B, §§ 3, 7; Minn. Stat. § 62Q.095(1); Miss. Code Ann. §§ 83-9-6(3)(b); N.H. Rev. Stat. Ann. § 420-B:12(V); N.J. Stat. Ann. §§ 17:48-6j(a)(2), -48E-35.7(a)(2), 17B-26-2.1i(a)(2), -27-46.1i(a)(2), 26:2J-4.7(a)(2); N.M. Stat. Ann. §§ 59A-46-35, -36; N.C. Gen. Stat. § 58-51-37; N.D. Cent. Code § 26.1-36-12.2(1)(c); S.C. Code Ann. § 38-71-147; S.D. Codified Laws § 58-18-37(1); Tex. Ins. Code Ann. § 21.52B(2)(a)(2); Utah Code Ann. § 31A-22-617(7)(b); Va. Code Ann. §§ 38.2-3407(B), -4209(C); Wis. Stat. § 628.36(b)(3), (e)(1); Wyo. Stat. Ann. §§ 26-34-134, -22-503(a)(iii).

as well as its specific holding in *Group Life & Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205 (1979), that agreements between insurers and third-party providers do *not* constitute the business of insurance. It also squarely conflicts with the holdings of the Fifth and Eighth Circuits that AWP statutes are preempted by ERISA. *Prudential Ins. Co. of Am.* v. *National Park Med. Ctr.*, 154 F.3d 812 (CA8 1998); *Texas Pharmacy Ass'n* v. *Prudential Ins. Co. of Am.*, 105 F.3d 1035 (CA5 1997); *Cigna Healthplan of La.* v. *Louisiana*, 82 F.3d 642 (CA5), *cert. denied*, 519 U.S. 964 (1996). In total, the AWP statutes of nine states have been challenged on ERISA preemption grounds (in at least fourteen different lawsuits), with a majority of courts finding in favor of preemption.

The question is also of great importance for the nearly ninety percent of non-elderly Americans who receive health benefits from ERISA plans. As has been recognized by numerous entities including the Federal Trade Commission, AWP statutes threaten to undermine seriously the ability of managed care organizations to contain costs and improve the quality of care delivered to their participants. See Pet. App. 94a-102a. Furthermore, "[v]irtually *every* legal scholar who has addressed the issue" regards AWP statutes "as an attempt by politically powerful interest groups in the medical community to protect their current income levels and jobs at the risk of significantly increasing the cost of health care and completely unraveling the optimal combination of cost control and quality that managed care has achieved." James W. Childs, Jr., *You May Be Willing, But Are You Able?: A Critical Analysis of "Any Willing Provider" Legislation*, 27 CUMB. L. REV. 199, 200 (1996-97) (emphasis added).

Certiorari should be granted.

1. Petitioners Community Health Partners, Inc., and Reservoir Park Health Services, Inc. (collectively "CHP" or "Petitioners") assemble panels of selected health care providers, including hospitals, pharmacies, and physicians of various specialties, to provide services on a preferred or exclusive ba-

sis for managed care entities and insurance companies, as well as for employers that provide health plans but do not carry any form of insurance (so-called "self-insured" or "self-funded" plans). CHP thus is not in any respect an "insurer": it does not underwrite participants' risks but rather is an intermediary between providers and health plans.

In 1996, petitioners sought to provide one of Kentucky's largest HMOs with a network of physicians that would have the exclusive right to care for that HMO's enrollees. Exclusivity was essential to the proposed arrangement because it guaranteed a large-enough patient base to allow the providers in the network to provide high-quality services at a reduced cost. The HMO advised petitioners that it could not agree to the exclusive arrangement, however, because Kentucky's AWP law requires that it admit any provider willing to abide by the plan's terms.

The Kentucky AWP statute provides that a "health insurer" may not exclude "any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer." Ky. Rev. Stat. Ann. § 304.17A-270. The statute defines "health insurers" broadly to include not merely traditional insurance companies but virtually all health plans other than self-funded ERISA plans. *Id.* § 304.17A-005(23) ("insurers" include insurance companies, HMOs, provider-sponsored health delivery networks, and "self-insurer[s] * * * not exempt from state regulation by ERISA"). Thus, ERISA plans are subject to the AWP statute whenever they contract for benefits through a "health insurer," because that insurer is precluded from selectively contracting with providers.[2]

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[2] The Kentucky AWP statute originally applied only to "health care benefit plans," Ky. Rev. Stat. Ann. § 204.17A-110(3) (Banks-Baldwin 1995), but it was subsequently amended to apply to

2. Because AWP statutes substantially impinge on the insurer-provider relationship by mandating that insured ERISA plans utilize open provider networks, petitioners brought this suit alleging that the Kentucky AWP statute is preempted. The district court concluded that the Kentucky AWP law "relates to" ERISA plans, see 29 U.S.C. § 1144(a) (ERISA "supercede[s] any and all State laws insofar as they may now or hereafter relate to any [covered] employee benefit plan"), but held that the statute was not preempted because it falls within ERISA's insurance savings clause, see *id.* § 1144(b)(2)(A) (preemption does not apply to "any law of any State which regulates insurance"). Pet. App. 4a-31a.

A divided panel of the Sixth Circuit affirmed. Pet. App. 32a-93a.[3] Initially, the court of appeals unanimously held that AWP statutes "relate to" ERISA plans in two respects.

"health insurers," which were defined to include basically all health benefit plans. See Pet. App. 35a-36a. As the panel below recognized, *id.* 44a, the statute's exemption for self-funded ERISA plans simply restates ERISA's "deemer" clause, which provides that such plans shall not be regarded as engaging in the business of insurance. See 29 U.S.C. § 1144(b)(2)(B).

The majority further concluded that the Kentucky AWP statute could not be applied to health benefit plans serving as administrators for self-funded ERISA plans, reasoning that any such application would be preempted by ERISA and that the AWP statute was not intended to apply in that circumstance in any event. Pet. App. 56a-57a, 59a n.15.

[3] A single panel of the Sixth Circuit contemporaneously considered and decided appeals from two district court opinions sustaining the Kentucky AWP statute: this case and a suit subsequently brought by the Kentucky Association of Health Plans. In this case, the court of appeals incorporated the majority and dissenting opinions in the *Kentucky Ass'n of Health Plans* case, see Pet. App. 2a, so references in this petition to the panel majority and dissent are to the opinions in that case.

AWP statutes (i) "refer to" ERISA plans because they expressly exclude self-funded ERISA plans, and (ii) have a prohibited "connection with" ERISA plans because they prohibit limited provider networks, thereby "effectively requir[ing] benefit plans to purchase benefits of a certain structure" and "directly affect[ing] the administration of the plans." *Id.* 47a, 49a; see also *id.* 62a n.16 (emphasizing that the "difference between a closed network of providers chosen by the insurer and an open network of providers consisting of all providers" is "an extremely significant difference" that "change[s] the conditions of the plan"). See generally *California Div. of Labor Stds. Enforce.* v. *Dillingham Constr., N.A.*, 519 U.S. 316, 324 (1997) (ERISA preempts state laws that "refer to" or have a "connection with" ERISA plans).[4]

The majority opinion of Senior District Judge Holshuh (sitting by designation) nonetheless concluded that AWP statutes are saved from preemption because they "regulate insurance." Although the majority began by characterizing ERISA's savings clause as "a broad and important exception" to ERISA preemption, it quickly acknowledged that "the scope of the savings clause has proved difficult to determine from its sparse language." Pet. App. 49a-50a; see also *id.* 37a ("the wording of the Act combined with the obvious federalism concerns involved have made it difficult to discern clear boundaries"); *id.* (noting that the "vexingly broad and ambiguous nature" of the preemption provision and its savings clause has been acknowledged by "[m]any courts" and given rise to "interpretational difficulties").

The majority began by inquiring "whether from a common sense view of the matter the contested statute regulates insurance," Pet. App. 52a, and opined that AWP statutes satisfy

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[4] Because petitioners do not contest (indeed, they endorse) the Sixth Circuit's unanimous determination that AWP statutes "relate to" ERISA plans, that holding will not be discussed any further.

that test because they are codified in states' insurance codes, *id.* 23a. The majority also relied on the fact that AWP statutes potentially expand the circumstances in which plan participants will be able to receive care from participating providers of their choice:

> [The AWP provisions] affect restrictions by the insurers on the number of health care providers available to the insureds under such plans; they increase benefits to the insureds by giving them greater freedom to choose health care providers under the plans; and they are aimed at regulating this insurance relationship.

Pet. App. 60a. The panel majority thus frankly conceded, but dismissed as irrelevant, that "AWP laws do not change the substantive terms of the insurance coverage." *Id.* 66a; see also *id.* (not disputing petitioners' argument that "the AWP provisions leave the contract terms between the insurer and the insured unaltered, the medical risks remain the same, and even if an insured's provider decides to join the insured's network, the medical coverage remains the same").

The majority found that AWP statutes also fall within the savings clause when considered in light of the three criteria developed under the McCarran-Ferguson Act to determine whether a practice constitutes the "business of insurance": (1) "whether the practice has the effect of transferring or spreading a policyholder's risk"; (2) "whether the practice is an integral part of the policy relationship between the insurer and the insured"; and (3) "whether the practice is limited to entities within the insurance industry." Pet. App. 50a-51a. See generally *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 743 (1985) (criteria under McCarran-Ferguson Act guide analysis under ERISA's savings clause).[5] Specifi-

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[5] Congress enacted the McCarran-Ferguson Act, 59 Stat. 33, *as amended*, 15 U.S.C. § 1011 *et seq.*, to preserve the rights of states to regulate insurance, in response to this Court's holding in *United*

cally, the court adopted the view of the Fourth Circuit in *Stuart Circle Hospital Corp.* v. *Aetna Health Management*, 995 F.2d 500, *cert. denied*, 510 U.S. 1003 (1993), that AWP laws satisfy the first two criteria because they expand the number of providers who may decide to join a plan and, in turn, provide benefits to the plan's participants. Pet. App. 60a-66a. In this respect, AWP statutes are said to "effectively create a mandatory contract term dealing with the manner in which the plan is administered" and thus "directly affect the administration of the plan." *Id.* 66a (citing *Stuart Circle*, 995 F.2d at 503). But see *id.* 60a (acknowledging that whether AWP statutes spread risk is "certainly a debatable issue").

Regarding the third McCarran-Ferguson factor, the court concluded that, although AWP statutes apply to entities such as HMOs and self-funded health plans, the statutes are limited to the "insurance industry" because those entities function in a manner akin to traditional insurers. Pet. App. 66a. The majority agreed with the view of "a well-known treatise," however, that "'[s]elf-insurance has often led courts and legislatures to struggle with the intriguing question of whether a party who has not purchased insurance, effectively acting as

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States v. *South-Eastern Underwriters Ass'n*, 322 U.S. 533 (1944), that the sale of insurance constitutes interstate commerce. See generally *United States Dep't of the Treasury* v. *Fabe*, 508 U.S. 491, 499-500 (1993) (discussing the Act's history). Section 1 of the Act provides that "silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of [the business of insurance] by the several States." 15 U.S.C. § 1011. Section 2(b) provides that federal law shall not be "construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance" unless that law "specifically relates to the business of insurance," and further provides that the federal antitrust laws "shall be applicable to the business of insurance to the extent that such business is not regulated by State law." *Id.* § 1012(b).

its own insurer, should be the equivalent of an insurer.'" *Id.* 54a (quoting 1 COUCH ON INSURANCE § 10.2 (3d ed. 1998)).

The panel majority also rejected petitioners' reliance on two decisions in which this Court held that agreements between insurers and third parties do *not* constitute the business of insurance: *Group Life & Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205 (1979) (agreements with participating pharmacies), and *Union Labor Life Insurance Co.* v. *Pireno*, 458 U.S. 119 (1982) (agreements with peer review panels used in claims determinations). The Sixth Circuit distinguished the reimbursement of third-party providers (such as in *Royal Drug*) from AWP statutes on the ground that the latter more directly affect plan participants' access to care. See Pet. App. 63a ("While Kentucky policyholders may be basically unconcerned with the insurers' compensation arrangements with participating providers, it cannot be said that they are unconcerned with a limitation on the number of such providers and the resulting restriction on their freedom of choice in seeking medical treatment.").

The majority finally asserted that its holding was supported by *United States Department of the Treasury* v. *Fabe*, 508 U.S. 491 (1993),[6] which indicated that a statute regulates the business of insurance if it is aimed at regulating the insurer-insured relationship "'directly or indirectly.'" Pet. App. 64a (quoting *Fabe*, 508 U.S. at 503). The majority also relied on this Court's statement in *Fabe*, 508 U.S. at 504, that *Royal Drug* and *Pireno* involved the McCarran-Ferguson Act's antitrust exemption rather than its general preemption provision. Pet. App. 64a-65a. The former addresses the "business of insurance" while the latter more broadly addresses state laws

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[6] *Fabe* held that a state law governing priority to claims on the assets of an insolvent insurer had the "purpose of regulating insurance" under the McCarran-Ferguson Act to the extent that it protected policyholders.

with "the *purpose* of regulating the business of insurance." 15 U.S.C. § 1012(b) (emphasis added).

Judge Kennedy dissented. She agreed with the majority that AWP laws "relate to" ERISA plans but strenuously disagreed with the majority's savings clause analysis. Judge Kennedy would have rejected the Fourth Circuit's reasoning in *Stuart Circle* and adopted instead the view of the Fifth and Eighth Circuits, which have struck down the AWP statutes of Arkansas, Louisiana, and Texas. Pet. App. 85a-89a; see also *id.* 90a (agreeing "with the Eighth Circuit's observation in *Prudential Ins. Co.* that, 'it is for Congress, not the courts, to reassess ERISA in light of modern insurance practices and the national debate over health care'" (quoting 154 F.3d at 829-30)). As Judge Kennedy explained:

> Rather than shifting risk from policyholders to insurers, Kentucky's AWP statutes merely prohibit benefit plans from excluding qualified providers who want to join the plan's provider network and are able to meet the plan's requirements. The risk assumed by the benefit plan under its policy, that the policyholder will require medical treatment, remains unaltered. The statute's passage in no way alters the terms of the policyholder's policies. The only contracts affected are those between the benefit plan and the providers already in the plan network.

Id. 80a.

3. After the Sixth Circuit denied rehearing and rehearing en banc, Pet. App. 31a, this petition followed.

REASONS FOR GRANTING THE WRIT

This case satisfies all of the criteria for Supreme Court review. The decision below conflicts with this Court's precedents, including particularly this Court's holding that agreements between insurers and third parties do not constitute the business of insurance. *Union Labor Life Ins. Co.* v. *Pireno*,

458 U.S. 119 (1982); *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205 (1979). The decision below also is in square conflict with decisions of the Fifth and Eighth Circuits holding that indistinguishable AWP statutes do not fall within ERISA's savings clause. *Prudential Ins. Co. of Am.* v. *National Park Med. Ctr.*, 154 F.3d 812 (CA8 1998); *Texas Pharmacy Ass'n* v. *Prudential Ins. Co. of Am.*, 105 F.3d 1035 (CA5 1997); *Cigna Healthplan of La.* v. *Louisiana*, 82 F.3d 642 (CA5 1996). The question presented is not only of undoubted importance – affecting the tens of millions of Americans who receive health care from ERISA-governed health plans – but also recurs frequently, as numerous state AWP statutes continue to be challenged on ERISA preemption grounds. Certiorari therefore should be granted.

I. The Decision Below Conflicts With This Court's Precedents.

The test for determining whether a statute is saved from ERISA preemption because it "regulates insurance," 29 U.S.C. § 1144(b)(2)(A), is well-settled. See *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 740-43 (1985); see also, *e.g.*, *UNUM Life Ins. Co.* v. *Ward*, 526 U.S. 358, 367 (1999) (same; quoting *Metropolitan Life*). The Court inquires whether the statute regulates insurance as a matter of "common sense," and also looks to the three criteria developed under the McCarran-Ferguson Act to determine whether a practice constitutes the "business of insurance": "first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry." *Metropolitan Life*, 471 U.S. at 743.

a. The "Common Sense" Test. The Sixth Circuit's determination that AWP laws regulate insurance "as a matter of common sense," Pet. App. 52a-60a, conflicts with this Court's precedents. The statutes that this Court has sustained

under the savings clause directly regulate either the insurer-insured relationship or the insurer itself. It was on this basis that *UNUM Life Insurance Co.* v. *Ward* held that California's notice-prejudice rule – under which an insurer must prove prejudice before denying an insured's claim as untimely – constitutes the regulation of insurance. 526 U.S. at 373 (inquiry is whether the statute "govern[s] the *insurance relationship* distinctively" (emphasis added)). Similarly, *FMC Corp.* v. *Holliday* held that Pennsylvania's subrogation rule – which prohibits insurance contracts from providing that payments to insureds will be recouped from tort recoveries – falls within the savings clause because it "controls the terms of insurance contracts." 498 U.S. 52, 61 (1990). Previously, *Metropolitan Life Insurance Co.* v. *Massachusetts* sustained a state law requiring that insurance policies include mental health benefits, explaining that the statute directly "regulates the terms of certain insurance contracts." 471 U.S. 724, 740 (1985). The Court also indicated in *John Hancock Mutual Life Insurance Co.* v. *Harris Trust & Savings Bank* that statutes directly regulating an insurer fall within the savings clause, sustaining in that case "[s]tate laws concerning an insurer's management of general account assets." 510 U.S. 86, 99 (1993).

Unlike the statutes in *UNUM Life*, *FMC*, *Metropolitan Life*, and *John Hancock*, AWP statutes regulate only the relationship between insurers and *third parties*. The statutes provide that insurers, HMOs, and other entities may not exclude those health care providers who are willing to abide by the plan's terms. The purpose and effect of AWP statutes is simply to grant providers who otherwise would be excluded from a health care network – because their quality is too low, their costs too high, their services unneeded, or for some other reason – the right to participate and make money from the plan's participants. State regulation of the determination whether to include or exclude such a provider is completely divorced from the "insurance relationship" and furthermore does not regulate the insurer itself.

The Sixth Circuit eschewed that reasoning, concluding instead that a statute regulates insurance as a matter of "common sense" whenever it is directed at insurers and potentially grants participants greater access to care. See *supra* at 7. But that approach vitiates the major principle limiting the scope of the savings clause, which extends only to "insurance" itself, as distinct from "the business of insurance companies" or "matters affecting insurers or insureds." Indeed, it is difficult to conceive of a statute applicable to insurance companies that would not fall within the savings clause based upon the Sixth Circuit's view that all statutes with an effect on policyholders are saved from preemption. This Court read ERISA's savings clause far more narrowly in *UNUM Life*, *FMC*, *Metropolitan Life*, and *John Hancock*.

b. The Three McCarran-Ferguson Criteria. The error of the panel majority is confirmed by this Court's precedents examining the three McCarran-Ferguson criteria, including particularly *Group Life & Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205 (1979), and *Union Labor Life Insurance Co.* v. *Pireno*, 458 U.S. 119 (1982). *Royal Drug* specifically held that the "business of insurance" does not encompass agreements between an insurer and its providers.[7] Provider agreements, the Court explained, can be said to involve the "business of insurance *companies*," but they do not involve "insurance," a term of art that describes spreading and underwriting risk. 440 U.S. at 211 (emphasis added). Indeed, the Court made quite clear that its holding extended to exclusive provider agreements indistinguishable from those addressed by AWP statutes, as when "an insurance company entered into a contract with a large retail drug chain whereby its policyholders could obtain drugs under their policies *only*

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[7] Under the agreements between Blue Cross and its participating pharmacists in that case, for each prescription, pharmacists received $2 from the insured and recouped from Blue Cross the cost of acquiring the drug.

from stores operated by this chain." *Id.* at 215 n.12 (emphasis added).

Royal Drug expressly holds that provider agreements do not satisfy *any* of the three McCarran-Ferguson criteria. Provider contracts do not constitute "the spreading and underwriting of a policyholder's risk" through the policy. 440 U.S. at 211. The Court thus distinguished between "the *obligations* of [an insurer] under its insurance policies, which insure against the risk that policyholders will be unable to pay * * * and the *agreements* between the [insurer] and the participating [providers], which serve only to minimize the costs [the insurer] incurs in fulfilling its underwriting obligations." *Id.* at 213 (emphasis added). Provider agreements also are not integral to the insured-insurer relationship or limited to entities in the insurance industry. *Id.* at 216. Instead, they constitute "separate contractual arrangements" between the insurer and providers, the latter of whom are "engaged in the sale and distribution of goods and services other than insurance." *Id.*

Subsequently, this Court in *Pireno* relied extensively on *Royal Drug* to hold that the "business of insurance" does not encompass an insurer's contract with a panel of physicians who were retained to determine whether to pay various claims. The Court acknowledged that the claims review process as a whole constitutes the "business of insurance." 458 U.S. at 134 n.8. But it rejected that conclusion as to the peer-review system, which is "logically and temporally unconnected to the transfer of risk accomplished by [the] insurance policies" and is "a separate arrangement between the insurer and third parties not engaged in the business of insurance." *Id.* at 130, 131. A practice constitutes the business of insurance, the Court explained, if it is "part of" the insurer-insured relationship. *Id.* at 130. *Pireno* thus held that the peer-review process was not part of the insurance relationship notwithstanding that it had the *effect* of both preventing certain providers from having access to plan enrollees and also preventing enrollees from receiving coverage for treatment.

The Sixth Circuit's holding that AWP statutes "regulate insurance" flatly conflicts with *Royal Drug* and *Pireno*. The panel majority opined that AWP statutes spread the "risk" that a policyholder will not be able to receive care under the terms of the plan from a participating provider of her choice. But that conception of "risk" is simply another way of saying that the statutes can potentially benefit insureds. It manifestly is not the "risk" that is "spread" or "underwritten" by the insurance contract as this Court's precedents require. *Royal Drug* thus specifically found with respect to provider networks that while "[s]uch cost-savings arrangements may well be sound business practice, and may well inure ultimately to the benefit of policyholders in the form of lower premiums * * * they are *not* the 'business of insurance.'" *Id.* at 214 (emphasis added). As Judge Kennedy explained in her dissent in this case, "any concerns over freedom of choice are beside the point. The critical issue with respect to the risk spreading prong, as well as whether the law regulates insurance as a matter of common sense, is whether or not the law is related to the risks underwritten by the insurer." Pet. App. 84a.

Nor do the AWP statutes regulate a practice that is "part of" the insurer-insured relationship, as this Court's precedents require. *Pireno*, 458 U.S. at 130. Petitioners' practice of maintaining a selective panel and thereby excluding other providers is no more a part of the insurer-insured relationship than the provider reimbursement policy in *Royal Drug* or the peer-review process in *Pireno*.

Finally, the decision below is in irreconcilable conflict with this Court's firm holding that agreements between insurers and third parties do not satisfy the third McCarran-Ferguson factor because they are not limited to entities within the insurance industry. In the first place, this Court has never endorsed the Sixth Circuit's view that "insurance" could be defined so broadly as to include every form of health benefit plan, as Kentucky law provides. See *supra* n.2. But even more important, the Sixth Circuit held that the third McCar-

ran-Ferguson criterion is satisfied so long as *one* of the parties to a regulated contract is an insurer. Pet. App. 66a-68a. Yet in both *Royal Drug* and *Pireno* it was undisputed that an insurer was a party to the contract in question. The relevant point for this Court was that the *other party* – the pharmacist in *Royal Drug* and the peer-review committee in *Pireno* – was not an insurer. AWP statutes are indistinguishable in that respect and the Sixth Circuit's error is plain.

The majority below also erred in attempting to distinguish *Royal Drug* and *Pireno* based on *United States Department of the Treasury* v. *Fabe*, 508 U.S. 491 (1993). Although *Fabe* explained that statutes aimed at regulating the insurer-insured relationship (whether directly or indirectly) generally satisfy the McCarran-Ferguson Act, see Pet. App. 64a, AWP statutes simply are *not* aimed at regulating that relationship. As the majority below frankly conceded, "AWP laws do not change the substantive terms of the insurance coverage." Pet. App. 66a. The court of appeals' holding that AWP statutes are nonetheless saved from preemption because they have an *effect* on policyholders rests on a highly attenuated relationship to "insurance" not approved by this Court's precedents. Certainly, policyholders were affected by the provider agreement in *Royal Drug* itself, which, although it may not have directly "restrict[ed] the number of providers in question," Pet. App. 62a, offered such a small reimbursement that numerous pharmacists could not afford to participate. See *Royal Drug*, 440 U.S. at 209 ("only pharmacies that can afford to distribute prescription drugs for less than this $2 markup can profitably participate in the plan"). Indeed, as noted above, *Royal Drug* itself makes clear that the Court's holding that provider agreements do not constitute the "business of insurance" applies fully to limited provider networks, as when "an insurance company entered into a contract with a large retail drug chain whereby its policyholders could obtain drugs under their policies *only from stores operated by this chain*." *Id.* at 215 n.12 (emphasis added).

In this respect, it is noteworthy that *Fabe* expressly acknowledged as good law *Royal Drug*'s holding that "an insurer's agreements with participating pharmacies to provide benefits to policyholders was *not* part of the business of insurance," 508 U.S. at 503 (emphasis added), and reiterated *Royal Drug*'s conclusion that "indirect effects" on the insurer-insured relationship are not "sufficient for a state law to avoid preemption," *id.* at 508-09. See also *id.* at 511-17 (Kennedy, J., dissenting, joined by Scalia, Souter, and Thomas, JJ.) (arguing for still broader reading of *Royal Drug* and *Pireno*).[8]

Ignoring *Fabe*'s endorsement of the *Royal Drug* analysis, the Sixth Circuit instead found significant *Fabe*'s explanation that *Royal Drug* and *Pireno* involved the McCarran-Ferguson Act's antitrust provision – which encompasses laws that regulate the "business of insurance" – rather than its general preemption provision – which more broadly encompasses all state laws with "the *purpose* of regulating the business of insurance." Pet. App. 65a. But the Sixth Circuit's reliance on *Fabe* has the analysis precisely backwards, for ERISA's savings clause does not include the broad "purpose" language of the McCarran-Ferguson Act's general preemption provision.[9] If anything, ERISA's savings clause, by referring only to statutes that "regulate[] insurance," is *narrower* than the

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[8] This Court has recently reiterated the vitality of the *Royal Drug* analysis, explaining that agreements between insurers and providers fall outside the "business of insurance," "as distinct from the broader 'business of insurance companies.'" *Hartford Fire Ins.* v. *California*, 509 U.S. 764, 783-84 (1993) (holding that agreements between insurers and reinsurers are within the business of insurance) (quoting *Royal Drug*, 440 U.S. at 233).

[9] Compare 29 U.S.C. § 1144(b)(2)(A) (ERISA does not preempt "any law of any State which regulates insurance") with 15 U.S.C. § 1012(b) (general federal law shall not be "construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance").

McCarran-Ferguson Act's reference in its antitrust provision to statutes that regulate the entire "business of insurance."

The conflict between the decision below and this Court's precedents merits this Court's review.

II. The Decision Below Exacerbates An Existing Circuit Conflict.

Certiorari is also warranted because the decision below exacerbates an entrenched conflict in the circuits regarding whether Any Willing Provider statutes are preempted by ERISA. The Fourth and Sixth Circuits hold that AWP statutes fall within ERISA's savings clause; the Fifth and Eighth Circuits flatly disagree. Even before the decision in this case, commentators had repeatedly recognized the circuit split. William J. Bahr, *Although Offering More Freedom To Choose, "Any Willing Provider" Legislation Is The Wrong Choice*, 45 KAN. L. REV. 557, 558 (1997) ("The existing precedent is conflicting. Some courts have held that the statutes are preempted by the Employee Retirement Income Security Act (ERISA), while other courts have concluded that the statutes are saved from preemption." (footnote omitted)); Vickie Yates Brown & Barbara Reid Hartung, *Managed Care at the Crossroads: Can Managed Care Organizations Survive Government Regulation?*, 7 ANNALS HEALTH L. 25, 39-40 (1998) ("A number of any willing provider statutes have been challenged on the grounds of ERISA preemption. * * * With one exception, the federal courts that have considered this question have found the statutes to be preempted."); Margaret G. Farrell, *ERISA Preemption & Regulation of Managed Health Care: The Case For Managed Federalism*, 23 AM. J.L. & MED. 251, 270 (1997) ("Courts have variously upheld and invalidated these laws against preemption challenges."); Larry J. Pittman, *"Any Willing Provider" Laws And ERISA's Savings Clause: A New Solution For An Old Problem*, 64 TENN. L. REV. 409, 427 (1997) ("ERISA plans have attacked any willing provider laws on the grounds that they are preempted by ERISA's preemption clause, and this has created a

split among federal courts with some finding preemption while others do not." (footnote omitted)); Patricia A. Butler, *ERISA Case Law Update*, HEALTH CARE FRAUD REP., May/June 2000, at 2 (noting that Eighth Circuit's decision in *National Park Medical Center* that ERISA preempts Arkansas AWP law "follow[ed] a majority of courts"). It therefore is apparent that the conflict will have to be "settled by the Supreme Court." John D. Blum, *The Evolution of Physician Credentialing Into Managed Care Selective Contracting*, 22 AM. J.L. & MED. 173, 201 (1996).

a. The Fourth Circuit. The Sixth Circuit's decision in this case expressly adopts the Fourth Circuit's holding that although AWP statutes "relate to" ERISA plans and ordinarily would be preempted, they fall within ERISA's savings clause. In *Stuart Circle Hospital Corp.* v. *Aetna Health Management*, the Fourth Circuit rejected an ERISA preemption challenge to Virginia's AWP law. 995 F.2d 500, *cert. denied*, 510 U.S. 1003 (1993); see also Va. Code Ann. § 38.2-3407(B) ("No hospital, physician or type of provider * * * willing to meet the terms and conditions offered to it or him shall be excluded."). The Fourth Circuit held that the statute "regulates insurance" because it "is part of a comprehensive code regulating accident and sickness insurance" and "regulates the 'relationship between insurer and insured'" by prohibiting "an insurer's unreasonable restriction of the insured's choice of physician and hospital." 995 F.2d at 503 (quotation marks omitted).

b. The Eighth Circuit. Subsequent to the Fourth Circuit's decision in *Stuart Circle*, the Eighth Circuit reached the opposite conclusion. In *Prudential Insurance Co. of America* v. *National Park Medical Center*, the Eighth Circuit held that Arkansas' AWP statute had a prohibited "relationship to" ERISA plans and furthermore did not fall within the savings clause. 154 F.3d 812 (1998). The Arkansas statute is indistinguishable from the Kentucky AWP statute at issue in this case. Accord *Ward* v. *Alternative Health Delivery Sys.*, 55 F.

Supp. 2d 694, 701 (W.D. Ky. 1999) (Arkansas and Kentucky AWP statutes are "almost identical"). Compare Ark. Code Ann. § 23-99-204(a)(3) ("A health care insurer shall not * * * [p]rohibit or limit a health care provider" willing to abide by the plan's terms), -209 (statute inapplicable "to self-funded or other health benefit plans that are exempt from state regulations by virtue of [ERISA]") with Ky. Rev. Stat. Ann. § 304.17A-270 ("A health insurer shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer."), -005(23) (statute inapplicable to "self-insurer[s] * * * exempt from state regulation by ERISA").

The panel majority in this case was fully aware of the Eighth Circuit's contrary decision, and the conflict between the Fourth and Sixth Circuits' holding that AWP statutes fall within ERISA's savings clause and the contrary view of the Eighth Circuit is entirely irreconcilable. The courts squarely disagree not only in their holdings, but as to *every step* of the savings clause analysis. Regarding the "common sense" test, the Eighth Circuit rejects the view adopted by the Fourth and Sixth Circuits that AWP statutes regulate insurance, holding that the savings clause applies only if the statute in question is "specifically directed toward" the insurance industry. 154 F.3d at 827. Of particular note is the conflict created by the Sixth Circuit's determination in this case that the savings clause encompasses far more than "traditional insurance companies" in light of "the natural evolution of the health insurance industry." Pet. App. 27a (quotation marks omitted). The Eighth Circuit takes the opposite position, holding that the "insurance industry" means "*traditional* insurance" and flatly rejects the argument that an AWP statute is "simply an 'innovative' insurance law." 154 F.3d at 829 (emphasis added). The Eighth Circuit thus holds that an AWP statute "is not a law directed at the insurance industry at all, but a law directed at regulation of broadly defined *health benefit plans*,

only *some* of which fall within the insurance industry." *Id.* (emphasis added); see also *id.* at 826 ("the definition of 'health care insurer' under the Arkansas [statute] is definitely not limited to 'insurance companies'"). The Eighth Circuit also finds it irrelevant that AWP statutes are codified in state insurance codes. *Id.* at 829. Contra Pet. App. 23a.

The circuits further disagree in their analysis of all three of the McCarran-Ferguson factors. Regarding the first factor, the Eighth Circuit relies on *Royal Drug* and *Pireno* to hold that because AWP statutes regulate only the relationship between health plans and third parties, they "plainly do[] not have the effect of transferring or spreading the policyholder's risk." 154 F.3d at 829. The Eighth Circuit also rejects the argument (adopted by the Sixth Circuit) that this Court's decision in *Fabe*, rather than *Royal Drug* and *Pireno*, controls the analysis of AWP statutes. See *id.* at 828. It therefore "decline[d] to adopt *Fabe*'s interpretation of laws 'enacted * * * for the purpose of regulating the business of insurance' * * * as necessarily the interpretation the Supreme Court would adopt for the ERISA savings clause." *Id.* The Fourth Circuit views the "policyholder's risk" much more broadly, encompassing the risks that treatment will not be available from the participant's physician of choice or will have to be secured at a higher cost. *Stuart Circle*, 995 F.2d at 503. The Sixth Circuit majority found that expansive view "certainly a debatable issue," but ultimately persuasive. Pet. App. 60a.[10]

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[10] The Sixth Circuit's broad conception of "risk spreading" for purposes of the McCarran-Ferguson Act also accords with the view of the Tenth Circuit, see *Blue Cross & Blue Shield of Kansas City* v. *Bell*, 798 F.2d 1331 (1986) (concluding that participant's choice of provider is implicit in risk sought to be insured through coverage), but conflicts with the Ninth and Eleventh Circuits' flat refusal to extend the first McCarran-Ferguson criterion beyond the specific "risk" underwritten by the insurer – *i.e.*, the risk that the policyholder will become ill and require coverage, see *Cisneros* v. *UNUM*

Regarding the second McCarran-Ferguson factor, the Eighth Circuit rejects the claim that AWP statutes affect "an integral part of the policy relationship" between insurer and insured, concluding that at most the statutes "might be an integral part of the relationship between the insurer and a third party to the insured-insurer relationship, the health care provider." 154 F.3d at 829. The contrary view, the court explained, would encompass "any contract an insurer might make with any other third party." *Id.* at 830. Again, the Fourth and Sixth Circuits expressly disagree, finding it sufficient that AWP statutes impact the insurer-insured relationship, and thus "effectively create a mandatory contract term dealing with the manner in which the plan is administered" and "directly affect the administration of the plan." Pet. App. 66a (citing *Stuart Circle*, 995 F.2d at 503).

Finally, the Eighth Circuit holds that AWP statutes are "not limited to entities within the insurance industry" because they encompass entities such as HMOs, preferred provider organizations, and physician hospital organizations, a determination in accord with that court's view that the McCarran-Ferguson Act's reference to the regulation of insurance applies to "traditional insurance." 154 F.3d at 829-30. By con-

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Life Ins. Co. of Am., 134 F.3d 939, 945-46 (CA9 1998) ("The Supreme Court has explained that the term 'risk' – as used in this factor – refers to the risk of injury for which the insurance company contractually agreed to compensate the insured."), *cert. denied*, 526 U.S. 358 (1999); *Smith* v. *Jefferson Pilot Life Ins. Co.*, 14 F.3d 562, 569 (CA11) ("The Supreme Court has explained that the risk-spreading principle concerns the nature of the coverage of the policy – in other words, the risks of injury that the insurance company will bear for the insured."), *cert. denied*, 513 U.S. 808 (1994); see also *Washington Physicians Serv. Ass'n* v. *Gregoire*, 147 F.3d 1039, 1047 (1998) (noting courts' disagreement regarding the question), *cert. denied*, 525 U.S. 1141 (1999). This Court specifically declined to disturb the Ninth Circuit's view in *UNUM Life*. See 526 U.S. at 374.

trast, the Sixth Circuit reads "insurance" much more broadly to encompass more than "traditional insurance companies." Pet. App. 66a.[11]

c. The Fifth Circuit. The entrenched conflict in the lower courts extends as well to the Fifth Circuit, which has held that the AWP statutes of both Louisiana and Texas are preempted by ERISA. *Texas Pharmacy Ass'n* v. *Prudential Ins. Co. of Am.*, 105 F.3d 1035 (1997); *Cigna Healthplan of La.* v. *Louisiana*, 82 F.3d 642 (1996). (The Louisiana Court of Appeals

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[11] The Eighth Circuit's analysis of the third McCarran-Ferguson factor cannot be distinguished on the ground that Kentucky's AWP statute applies only to benefits provided by a "health insurer" – construed by the Sixth Circuit majority not to include entities serving only in an administrative capacity to self-funded ERISA plans, Pet. App. 56a-57a & 59a n.15 – as opposed to all "health benefit plans." Even on the view of the majority below, the Kentucky statute *does* apply to health plans operating as administrators to non-ERISA plans (such as church and government plans). *Id.* 58a n.14. Moreover, the Eighth Circuit specifically held that it would reach the same result even if the Arkansas statute were construed as similarly limited to health insurers, because the Arkansas AWP statute applies not only to third-party administrators but also to various other entities that are not traditional insurers:

> Even if we were to accept appellants' argument that the Arkansas PPA regulates "health care insurers," as defined, rather than "health benefit plans," it is clear that the statutory term "health care insurers" also goes well beyond the scope of the insurance industry, because it is defined by the statute to include, but not be limited to, insurance companies, hospital and medical services corporations, health maintenance organizations, preferred provider organizations, physician hospital organizations, third-party administrators, and prescription benefit management companies authorized to administer, offer, or provide health benefit plans.

154 F.3d at 829.

also reached the same conclusion regarding that state's statute. *Murphy* v. *Community Health Network of La.*, 712 So. 2d 296 (1998).) The Fifth Circuit, like the Eighth, holds that AWP laws do not "regulate insurance" because they are not "limited to entities within the insurance industry" – *i.e.*, they apply to HMOs as well as employers and pharmacy organizations. *Texas Pharmacy Ass'n*, 105 F.3d at 1038; see also *Cigna Healthplan of La.*, 82 F.3d at 650 (savings clause does not apply because AWP statutes apply to, *inter alia*, self-funded organizations and employers).

It is apparent that the Fifth Circuit's decisions in *Texas Pharmacy Ass'n* and *Cigna Healthplan* (unlike the Eighth Circuit's decision in *National Park Medical Center*) do not analyze all of the considerations relevant to whether a state statute "regulates insurance" for purposes of the savings clause. Relying on then-applicable Fifth Circuit precedent holding that a state law must satisfy all three McCarran-Ferguson criteria to be saved from preemption, the Fifth Circuit invalidated the Louisiana and Texas AWP statutes because they were not limited to the insurance industry. See *Texas Pharmacy Ass'n*, 105 F.3d at 1039; *Cigna Healthplan of La.*, 82 F.3d at 650. Subsequently, however, the Fifth Circuit has applied the full analysis under the savings clause and reaffirmed its holding and analysis in *Texas Pharmacy Ass'n* and *Cigna Healthplan of Louisiana*, and furthermore has indicated its approval of the Eighth Circuit's decision in *National Park Medical Center*. In *Corporate Health Insurance* v. *Texas Department of Insurance*, the Fifth Circuit held that ERISA's savings clause does not encompass statutes that apply to "employers and others not engaged in insurance practices." 215 F.3d 526, 538 & nn. 50-51 (2000) (citing *National Park Med. Ctr.*, 154 F.3d at 825; *Texas Pharmacy Ass'n*, 105 F.3d at 1039; *Cigna Healthplan of La.*, 82 F.3d at 650), *pet. for cert. pending sub nom. Montemayor* v. *Corporate Health Ins.* (No. 00-665). Furthermore, and of particular relevance to this Court's certiorari determination, petitioners

are advised that, based on the holdings of the Fifth Circuit and Louisiana Court of Appeals, insurance officials in both Louisiana and Texas are not enforcing their AWP statutes.

In sum, absent review by this Court, AWP statutes will be enforceable in some states, unenforceable in others, and nonexistent in the rest. Group health plans that operate across state lines will face a crazy quilt of regulation regarding their provider relationships, precisely the result ERISA's preemption clause was enacted to prevent. By adopting an excessively broad interpretation of the savings clause, the Sixth Circuit's decision in this case, the Fourth Circuit's ruling in *Stuart Circle*, and district court decisions reaching the same conclusion (see *infra* 26 n.13) deprive group health plans of the benefit of uniform national standards that Congress intended ERISA to provide. See *N.Y. State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 656-57 (1995) ("We have found that in passing §§ 514(a), Congress intended 'to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government * * * , [and to prevent] the potential for conflict in substantive law * * * requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.'" (quoting *Ingersoll-Rand Co.* v. *McLendon*, 498 U.S. 133, 142 (1990)) (alterations in *Travelers*)).

The clear, entrenched circuit conflict merits this Court's review.

III. The Question Presented Is Frequently Litigated And Of Manifest National Importance.

a. Certiorari is also warranted because the question whether ERISA preempts AWP statutes is among the most fiercely contested and litigated issues in health law, resulting in a division in the lower courts that is intolerable for a fed-

eral statute that is premised on national uniformity. The marked, negative impact of AWP legislation on managed care has led ERISA plans and related entities to challenge such statutes repeatedly. The question has been litigated with respect to the AWP statutes of nine different states in at least fourteen different lawsuits, with courts sustaining the statutes of Kentucky, Maine, Massachusetts, and Virginia, but invalidating those of Alabama, Arkansas, Georgia, Louisiana, and Texas.[12] It thus is no exaggeration to say that the controversy over AWP laws has been greater than with respect to "any other state law regulating managed care organizations." Pittman, *supra*, 64 TENN. L. REV. at 428; see also Kathy L. Cerminara, *Protecting Participants in and Beneficiaries of ERISA-Governed Managed Health Care Plans*, 29 U. MEM. L. REV. 317, 350 n.174 (1999) ("States' any-willing-provider statutes * * * are often challenged as being preempted by ERISA.").

The conflict over this frequently litigated question is not surprising, given that the lower courts have expressed substantial doubts regarding how to resolve ERISA preemption

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[12] In addition to the appellate decisions cited *supra*, see, *e.g.*, *Witt* v. *Aetna U.S. Healthcare*, No. 00-31-B-C, 2000 U.S. Dist. LEXIS 13264 (D. Me. Sept. 14, 2000) (statute sustained); *Ward* v. *Alternative Health Delivery Sys.*, 55 F. Supp. 2d 694 (W.D. Ky. 1999) (invalidated, but conclusion disapproved by Sixth Circuit in this case); *American Drug Stores* v. *Harvard Pilgrim Health Care*, 973 F. Supp. 60 (D. Mass. 1997) (sustained); *Blue Cross & Blue Shield of Ala.* v. *Nielsen*, 917 F. Supp. 1532 (N.D. Ala. 1996) (invalidated), *vacated as moot*, 142 F.3d 1375 (CA11 1998); *Hayden* v. *Blue Cross & Blue Shield of Ala.*, 843 F. Supp. 1427 (M.D. Ala. 1994) (invalidated); *HCA Health Servs.* v. *Aetna Life Ins. Co.*, 803 F. Supp. 1132 (E.D. Va. 1992) (invalidated, but conclusion disapproved by Fourth Circuit in *Stuart Circle*); *General Motors Corp.* v. *Caldwell*, 647 F. Supp. 585 (N.D. Ga. 1986) (invalidated); *Blue Cross & Blue Shield of Ala.* v. *Peacock's Apothecary*, 567 F. Supp. 1258 (N.D. Ala. 1983) (invalidated).

challenges to AWP statutes. Further guidance from this Court is therefore essential. Thus, in the course of invalidating Arkansas' statute, the Eighth Circuit agreed with concerns expressed by the Fifth Circuit:

> There is room to doubt if ERISA's drafters intended that it would preempt any-willing-provider statutes. We nevertheless conclude that the result in this case is compelled by the unmistakable breadth of ERISA preemption recognized by the Supreme Court. *A different result will require further guidance from the Supreme Court or further action from Congress.*

Prudential Ins. Co. of Am., 154 F.3d at 830 (quoting *Texas Pharmacy Ass'n*, 105 F.3d at 1039-40 (emphasis added)). Concomitantly, in rejecting petitioners' ERISA preemption challenge to Kentucky's AWP statute, the panel majority in this case took care to point out that "the scope of the savings clause has proved difficult to determine from its sparse language." Pet. App. 50a. The majority noted its uncertainty regarding several other aspects of its analysis as well. *Id.* 37a ("the wording of the Act combined with the obvious federalism concerns involved have made it difficult to discern clear boundaries"); *id.* (noting that the "vexingly broad and ambiguous nature" of preemption and savings provisions has been acknowledged by "[m]any courts" and caused "interpretational difficulties"); *id.* 54a (noting uncertainty regarding proper treatment of self-funded entities as insurers).

Nor is there any prospect that the dispute over ERISA's preemption of AWP statutes will dissipate. Not only have nearly half the states already adopted AWP laws, see *supra* at 2 n.1, but "adoption of any-willing-provider laws has gained momentum in recent years," Karen Jordan, *Managed Competition and Limited Choice of Providers: Countering Negative Perceptions Through A Responsibility To Select Qualified Network Physicians*, 27 ARIZ. ST. L.J. 875, 915 (1995), resulting in a "frenzy of activity" as state legislatures continue to include restrictions on provider networks in state health

care legislation, Recent Legislation, *Health Care Law – HMO Regulation – Arkansas Requires HMOs To Accept Any Provider Willing To Join Their Networks*, 109 HARV. L. REV. 2122, 2124 (1996).

b. The importance of the question presented for the eighty-eight percent of non-elderly Americans who are covered by ERISA health benefit plans, see *California Div. of Labor Stds. Enforce.* v. *Dillingham Constr., N.A.*, 519 U.S. 316, 327 n.5 (1997), is manifest. Over the more than twenty years since *Royal Drug* was decided, managed care has expanded enormously under the protective umbrella that ERISA provides employer-sponsored health plans. Recently, however, managed care has been threatened by any willing provider mandates.

As commentators have recognized, "[t]he *essence* of managed care is the control of medical costs through the use of a limited panel of providers and a gatekeeper who controls access to specialists." Brown & Hartung, *supra*, 7 ANNALS HEALTH L. at 36 (emphasis added); see also John P. Little, *Managed Care Contracts Of Adhesion: Terminating The Doctor-Patient Relationship And Endangering Patient Health*, 49 RUTGERS L. REV. 1397, 1463 (1997) ("[i]n capitation and risk sharing systems, the number of physicians needs to be limited because each physician requires a large number of [managed care organization] patients in order to spread the financial risk of having a small population of very sick patients."). AWP statutes, however, "undermine the ability of efficient provider networks to promise increased volume in exchange for providers' acceptance of rate reductions and constraints on utilization." David L. Meyer & Charles F. Rule, *Health Care Collaboration Does Not Require Substantive Antitrust Reform*, 29 WAKE FOREST L. REV. 169, 179-80 (1994). The facts of this case illustrate the point vividly, as Kentucky's AWP statute blocked petitioners' effort to provide low-cost, high-quality services to a Kentucky HMO through a select panel of providers.

In this fashion, AWP statutes can "significantly increase the cost of health care." Bahr, *supra*, 45 KAN. L. REV. at 583; see also *NCA Health Servs. of Va.* v. *Metropolitan Life Ins. Co.*, 752 F. Supp. 202, 204 (E.D. Va. 1990) ("The exclusion of some providers is a necessary prerequisite of a limited provider network. It is by limiting the number and types of providers included in a [HMO] that an [administrator] is able to implement cost reductions in services for health beneficiaries."). Not only do AWP statutes significantly increase administrative costs, Brown & Hartung, *supra*, 7 ANNALS HEALTH L. at 37-38, but even more importantly:

> Cost containment is threatened because requiring [a managed care network ("MCN")] to accept any provider willing to abide by terms, fees, conditions, and compensation diminishes an MCN's bargaining power with providers. The primary incentives for providers to engage in competitive bidding are the fear of losing market share by not being a participant in an MCN, and conversely, the guaranteed utilization levels that a closed panel MCN can offer.

Jordan, *supra*, 27 ARIZ. ST. L.J. at 917 (footnote omitted). Indeed, there is a substantial concern that by forbidding limited provider networks, AWP statutes threaten the ability of insurers to "exclude providers * * * who do not provide quality care." Arnold Celnicker, *A Competitive Analysis of Most Favored Nations Clauses in Contracts Between Health Care Providers and Insurers*, 69 N.C. L. REV. 863, 882 n.125 (1991); see also Jordan, *supra*, 27 ARIZ. ST. L.J. at 918 ("More importantly, however, any-willing-provider laws greatly hinder quality assurance.").

It therefore is no surprise that there has been a "*mountain* of scholarly commentary against any willing provider laws." Pittman, *supra*, 64 TENN. L. REV. at 431 (emphasis added); see also Childs, *supra*, 27 CUMB. L. REV. at 200 (noting consensus against AWP statutes of "[v]irtually every legal scholar who has addressed the issue"); David A. Hyman,

Consumer Protection in the Managed Care World: Should Consumers Call 911?, 43 VILL. L. REV. 409, 412 (1998) (AWP statutes represent health care reform "hijacked to serve the economic interests of health care providers who were losing market share, autonomy and income to managed care"). Joining this chorus of criticism is the Federal Trade Commission, which has repeatedly stated its view that "'any willing provider' requirements may discourage competition among providers, in turn raising prices to consumers and unnecessarily restricting consumer choice in pre-paid health care programs, without providing any substantial public benefit." Pet. App. 100a; see also *id.* 95a-96a nn.3-4.

This Court's intervention is accordingly warranted.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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February 12, 2001

APPENDIX

Community Health Partners, Inc.;
Reservoir Park Health Services, Inc.,
doing business as Center Care,
Plaintiffs-Appellants,
v.
Commonwealth of Kentucky; George Nichols,
Commissioner of Insurance.
Defendants-Appellees.

No. 98-5941

United States Court of Appeals
for the Sixth Circuit

Before: KENNEDY and NORRIS, Circuit Judges; HOLSCHUH,* District Judge.

HOLSCHUH, J. delivered the opinion of the Court, in which NORRIS J., joined KENNEDY, J., concurred in part and dissented in part.

HOLSCHUH, District Judge. Plaintiffs-Appellants, Community Health Partners, Inc. and Reservoir Park Health Services, Inc., assemble and market networks of select health care providers. They brought suit against the Commonwealth of Kentucky and against George Nichols, the Commissioner of Insurance, seeking declaratory and injunctive relief. Plaintiffs-Appellants claim that Ky. Rev. Stat. Ann. § 304.17A-110(3), an "Any Willing Provider" ("AWP") statute, is pre-

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*Honorable John D. Holschuh, United States District Judge for the Southern District of Ohio, sitting by designation.

empted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1144(a).[1] The district court found that, although the AWP law "relates to" ERISA plans and would therefore be pre-empted by ERISA, the law was saved from preemption as a regulation of insurance under ERISA's savings clause, 29 U.S.C. § 1144(b)(2)(A).

On this same date, this Court has decided the companion case of *Kentucky Association of Health Plans, Inc., et al. v. Nichols,* No. 98-6308. In that case, we held that Kentucky's AWP statute, Ky. Rev. Stat. Ann. § 304.17A-270 (formerly § 304.17A-110(3)), does "relate to" and is "connected with" ERISA plans and would therefore be pre-empted by ERISA.[2] However, we found that AWP statute fell within ERISA's savings clause, which saves state laws that relate to ERISA plans from pre-emption so long as they "regulate insurance." Specifically, we found that the AWP statute in question regulates insurance from a "common sense" view of the matter, and that it satisfies the three prongs of the *McCarran-Ferguson* test. For the reasons set forth in *Kentucky Association of Health Plans, Inc., et al. v. Nichols*, the judgment of the district court in this case is affirmed.

KENNEDY, Circuit Judge, concurring in part and dissenting in part. For the reasons set forth in her opinion in *Kentucky Association of Health Plans, Inc., et al. v. Nichols*, Judge Kennedy concurs with the conclusion that the AWP statute "relates to" and is "connected with" ERISA plans.

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[1] Ky. Rev. Stat. Ann. § 304.17A-110(3) was repealed by the Kentucky legislature effective July 1, 1999, and replaced with a similar AWP provision, now located at Ky. Rev. St. Ann. § 304.17A-270. Because of the similarities between the two statutes, the parties agree that the repeal did not render this appeal moot.

[2] Also at issue in *Kentucky Ass'n of Health Plans, Inc.* was the validity of Ky. Rev. Stat. Ann. § 304. 17A-171, which included an AWP provision in the statute governing chiropractors. That statute is not at issue in this case.

However, she dissents from the conclusion that the statute falls within ERISA's savings clause as a statute that regulates insurance.

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF KENTUCKY
BOWLING GREEN DIVISION

CIVIL ACTION NO. 1:96-CV-202-M

COMMUNITY HEALTH PARTNERS, INC.
and RESERVOIR PARK HEALTH
SERVICES,.INC. d/b/a CENTER CARE,
Plaintiffs,

VS.

COMMONWEALTH OF KENTUCKY
ex rel. GEORGE NICHOLS III,
COMMISSIONER OF INSURANCE,
Defendant,

MEMORANDUM OPINION AND ORDER

This matter is before the Court on Cross-Motions for Summary Judgment by Plaintiffs, Community Health Partners, Inc. [hereinafter "Community Health"] and Reservoir Park Health Services, Inc. d/b/a Center Care [hereinafter "Center Care"], and Defendant, Commonwealth of Kentucky, ex rel. George Nichols III, Commissioner of Insurance [hereinafter "Defendant"]. Plaintiffs seek declaratory and injunctive relief based on allegations that Kentucky's "Any Willing Provider" law, KRS 304.17A- 110(3), is pre-empted by the Employee Retirement Income Security Act, 29 U. S. C. § § 1001, *et seq.* [hereinafter "ERISA"]. The Court's jurisdiction over this matter is based on federal question pursuant to 28 U.S.C. § 1331.

1. STATEMENT OF FACTS

Plaintiffs, Community Health and Center Care, are networks of select health care providers -- physicians, hospitals and others -- which contract to provide health care services to beneficiaries of health care plans, either directly or through insurance companies and health maintenance organizations [hereinafter "HMOs"].[1] Community Health and Center Care contract with health care providers to participate in their networks.[2] Providers agree to provide health care services at predetermined rates, which the providers are usually willing to discount in return for the guarantee of a high volume of patients. Plaintiffs then market their provider networks to consumers -- either directly or through employers, insurance companies, HMOs and other groups -- and offer consumers economic incentives to patronize their network providers.

Enacted in 1994 as part of a comprehensive legislative effort to reform the state's health care industry, Kentucky's "Any Willing Provider" [hereinafter "AWP"] law states that

> [h]ealth care benefit plans shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and is willing to meet the terms and conditions for participation established by the health benefit plan.

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[1] An HMO is an organization in which the HMO itself and/or physicians participating in the HMO accept contractual responsibility for the delivery of certain health care services to HMO members in exchange for an advance capitation payment. *See generally* Barry R. Furrow et al., *Health Law* § 11-11 (1995). In this manner, the HMO assumes financial risk similar to that assumed by a traditional insurance company.

[2] Community Health is operated by a for-profit corporation owned by physicians and Commonwealth Health Corporation, which operates the Medical Center in Bowling Green, Kentucky. Center Care is owned by Commonwealth Health Corporation.

KRS 304.17A-110(3). As used in the statute, the term, "health benefit plan" means

> any hospital or medical expense policy or certificate; nonprofit hospital, medical-surgical, and health service corporation contract or certificate; a health benefit plan offered by a provider-sponsored integrated delivery network; a self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA; health maintenance organization contract; and standard and supplemental health benefit plan as established in KRS 304.17A-160.

KRS 304.17A-100(4)(a).

At the time of the AWP statute's enactment, Center Care had an exclusive agreement with an affiliate of CHA HMO, Inc. [hereinafter "CHA"] for the provision of health care providers for certain CHA products. CHA is a licensed Kentucky HMO. During the fall of 1996, Community Health attempted to negotiate an exclusive agreement with CHA for provision of a different managed care product. Community Health was unable to solidify an agreement with CHA after Defendant determined that the CHA/Community Health agreement would violate the AWP law. Defendant maintained that the CHA/Community Health agreement would violate the AWP statute by preventing an excluded provider, who was otherwise willing to accept the terms and conditions of the CHA/Community Health agreement, from providing services to CHA enrollees.

In response, Plaintiffs filed the present action. Plaintiffs maintain that Kentucky's "Any Willing Provider" law threatens their existence by effectively preventing them from contracting with any entity mentioned in KRS 304.17A-100(4) for the provision of selective provider services. Plaintiffs ask the Court to find the AWP preempted by ERISA and to enjoin Defendant from enforcing the statute.

II. STANDARD OF REVIEW

In order to grant a motion for summary judgment, the court must find that the pleadings, together with the depositions, interrogatories and affidavits, establish that there is no genuine issue of material fact and that the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56. The moving party bears the initial burden of specifying the basis for its motion and of identifying that portion of the record which demonstrates the absence of a genuine issue of material fact. *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986). Once the moving party satisfies this burden, the non-moving party thereafter must produce specific facts demonstrating a genuine issue of fact for trial. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-48 (1986). Since the Parties do not dispute the material facts in this case, summary judgment is an appropriate means of resolving the legal issues underlying this dispute.

III.

Enacted in 1974, ERISA is a comprehensive statute which subjects employee benefit plans, including pension and welfare plans, to federal regulation. *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90 (1983). Welfare benefit plans include programs providing benefits to employees for "medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability [or] death," whether these benefits are provided "through the purchase of insurance or otherwise." 29 U.S.C. § 1002(l); *see also New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 545, 651 (1995). Thus, ERISA applies both to self-insured employee health benefit plans as well as to plans that purchase health insurance for their participants.

Initially, Defendant challenges whether Plaintiffs have standing to bring the present action. Having rejected this argument in a previous Order, the Court finds no need to further address the standing issue.

A. ERISA Preemption Principles

ERISA supersedes any and all State laws insofar as they "relate to" an employee benefit plan. 29 U.S.C. § 1144(a). However, Congress imposed a limit on ERISA preemption by including a "saving" clause in the Act's provisions. The saving clause exempts from preemption "any law of any State which regulates insurance." 29 U.S.C. § 1144(b)(2)(A). Therefore, the Court must first determine whether the AWP law is preempted by ERISA because the law "relates to" an employee benefit plan. If the AWP law "relates to" an employee benefit plan within the meaning of ERISA, the Court must next ascertain whether the law is "saved" from preemption as a law which regulates insurance.

1. "Relates To" Analysis

As previously mentioned, ERISA preempts any and all State laws that "relate to" an employee benefit plan. The Supreme Court has explained that a state law "relates to" an employee benefit plan for purposes of ERISA "if it has a connection with or reference to such a plan." *Shaw*, 463 U.S. at 97.

a. "Reference to" an ERISA Plan

It is undisputed that the Kentucky statute makes an express reference to ERISA plans. Plaintiffs argue that this reference, in itself, is sufficient to trigger preemption. To support this argument, Plaintiffs rely on *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 129 (1992). In *Greater Washington Bd. of Trade*, the Supreme Court considered whether ERISA preempted a state workers compensation law which provided that

> [a]ny employer who provides health insurance coverage for an employee shall provide health insurance coverage equivalent to the existing health insurance coverage of the employee while the employee receives or is eligible to receive workers' compensation benefits under this chapter.

Id. at 128. Plaintiffs emphasize the statement in *Greater Washington Bd. of Trade* that the statute "specifically refers to welfare benefit plans regulated by ERISA and on that basis alone is pre-empted." *Id.* at 130.

Plaintiffs also argue that the AWP statute "refers to" employee benefit plans because it directly regulates self-insured insurance plans. Plaintiffs point out that, by its terms, the Kentucky statute applies to "self-insured or multiple employee welfare arrangements, to the extent permitted by ERISA." Plaintiffs reason that since ERISA allows for limited state regulation of multiple employee welfare arrangements[3] [hereinafter "MEWAs"] but not self-insured ERISA plans, the Kentucky legislature meant the phrase "to the extent permitted by ERISA" to apply only to MEWAs. Therefore, Plaintiffs' argument continues, the AWP statute specifically "refers to" ERISA plans because it explicitly subjects self-insured ERISA plans to its provisions.

Although Kentucky's AWP law does explicitly mention self-insured employee benefit plans and MEWAs,[4] the Court

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[3] 29 U.S.C. § 1144(b)(6)(A)(ii) allows States to regulate certain MEWAs to the extent state law is "not inconsistent with" ERISA.

[4] The fact that the Kentucky legislature chose to allow for regulation of MEWAs and self-insured plans "to the extent permitted by ERISA" suggests that the legislature was well aware of the preemptive force of ERISA. As noted by Defendant, the phrase appears merely to restate the "deemer clause" by exempting self-insured ERISA plans from the scope of the AWP statute. The "deemer clause" prevents a state law from "deeming" an employee benefit plan to be an insurance company for the purpose of any law purporting to regulate the business of insurance. 29 U.S.C. 1144 (b)(2)(B). The deemer clause thus effectively prevents states from subjecting self-insured plans to state insurance regulation. On the other hand, insured plans -- plans that purchase insurance -- are subject to state laws regulating the insurance industry. *See, Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732 (1985).

rejects that mere reference alone is sufficient to trigger preemption. First, the Sixth Circuit specifically rejected this proposition in *Thiokol Corp. v. Roberts*, 76 F.3d 751, 759 (6th Cir. 1996) (holding that mere reference is not enough to trigger preemption; rather, law must clearly have a significant effect on employee benefit plans), *cert denied*, 117 S.Ct. 2448 (1997). Moreover, the Supreme Court recently clarified its "reference to" analysis by articulating two situations where "reference to" an employee benefit plan is sufficient to result in preemption. *See California Div. of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc.*, ____ U.S. ____, 117 S.Ct. 832, 838 (1997).

First, the Supreme Court clarified that state law makes a "reference" to ERISA where the law acts "immediately and exclusively" upon ERISA plans. *Id.* (citing *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 829 (1988)). In *Mackey*, the statute at issue singled out ERISA employee welfare benefit plans for exemption from otherwise generally applicable state garnishment procedures.[5] *Id.* at 829. In holding the statute preempted because it "referred to" an employee benefit plan, the Court found significant the fact that the statute *solely* applied to ERISA employee benefit plans. *Id.* In the present case, although the AWP law does explicitly mention self-insured employee benefit plans and MEWAs, it does not act "immediately and exclusively" upon employee benefit plans since not all of the plans defined in the statute are employee benefit plans. Rather, the AWP law generally affects plans or contracts of insurance offered by risk-bearing entities.

Second, the Supreme Court clarified that state law "refers to" ERISA covered plans where the "existence of ERISA

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[5] The Georgia statute barred the garnishment of "[f]unds or benefits of [an]...employee benefit plan or program subject to...[ERISA]." *Id.* at 828 (quoting Ga. Code Ann § 18-4-22.1 (1982)).

plans is essential to the law's operation." *Dillingham*, 117 S.Ct. at 834 (citing *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 124, 130 (1992); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 132 (1990)). In *Greater Washington Bd. of Trade*, the statute in question provided that "any employer who provides health insurance coverage for an employee" must provide "health .insurance coverage equivalent to the existing health insurance coverage of the employee" while the employee is receiving or eligible to receive workers compensation benefits. *Id.* at 128. In concluding that the statute was preempted because it "referred to" employee benefit plans, the Court found significant that the statute imposed requirements on employers by reference to ERISA-covered programs. *Id.* at 130-31. Operation of the statute was premised on the existence of an employee health benefit plan. *Id.* at 131.

In *Ingersoll-Rand*, 498 U.S. at 135, the Supreme Court considered whether ERISA preempted an employee's state law cause of action for wrongful discharge. In holding the cause of action preempted, the Supreme Court again relied heavily on the fact that the state law cause of action was premised on the existence of an employee pension plan.

> [T]he cause of action 'allows recovery when the plaintiff proves that the principal reason for his termination was the employer's desire to avoid contributing to or paying benefits under the employee's pension fund.' Thus, in order to prevail, a plaintiff must plead, and the court must find, that an ERISA plan exists and the employer had a pension-defeating motive in terminating the employment....*[T]here simply is no cause of action if there is no plan.*

Id. at 140. [Emphasis added] [Internal citations omitted]

In the present case, on the other hand, the existence of employee benefit plans is not *essential* to the operation of Kentucky's AWP law. By definition, the statute applies to

the contracts or "plans" by which certain entities assume financial risk for various health-related occurrences. Although ERISA self-insured employee welfare benefit plans and MEWAs are among the risk-bearing entities referenced in the statute, these ERISA plans are by no means the *only* entities affected by the statute. Moreover, although the non-ERISA entities -- such as insurance companies and HMOs -- defined in the statute primarily contract directly with insured ERISA plans, they also contract with private individuals and groups not affected by ERISA. *See Travelers Ins. Co. v. Cuomo*, 14 F.3d 708, 711 (2d Cir. 1993) (noting that "[88%] of non-elderly Americans have private health care insurance through [ERISA] plans), *rev'd on other grounds by New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995). Thus, the health benefit plans defined in Kentucky's AWP law need not necessarily be ERISA plans.

b. "Connection with" an ERISA Plan

A law that does not "refer to" ERISA plans may still be preempted if it has a "connection with" ERISA plans. *Dillingham*, 117 S.Ct. at 838. Plaintiffs argue that the AWP law has a connection with ERISA plans because the law effectively requires all health benefit plans to include in their provider panels any provider willing to accept the terms and conditions offered by the plan. Plaintiffs contend that the law thus effectively mandates the benefit structure and administration of insured ERISA plans by precluding them from structuring their plans around preferred provider arrangements. In this regard, Plaintiffs argue that Kentucky's AWP statute is similar to the mandated benefit law in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985).

In *Metropolitan Life*, the Court considered whether a state law mandating mental health benefits for certain types of insurance coverage "relates to" ERISA plans. *Id.* at 731-32. The statute at issue specified that minimum mental health benefits be provided all Massachusetts residents insured un-

der a general insurance policy, an accident or sickness insurance policy, or an employee health care plan covering hospital and surgical expenses. *Id.* at 727. The Court held that the mandated benefit law "relates to" ERISA plans because the statute bore "indirectly but substantially" on all insured employee benefit plans by effectively requiring the plans to purchase the mental health benefits when purchasing a certain kind of common insurance policy. *Id.* at 739.

Courts have applied this same rationale to hold a state law preempted if it restricts the choices of a benefit plan regarding the plan's administration, structure, or benefits. *See, e.g., FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990) (ERISA preempts state antisubrogation statute restricting structure of ERISA plans); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U. S. 504, 505 (1981) (ERISA preempts state statute insofar as statute prevents ERISA plans from decreasing benefits); *United Wire Metal & Machine Health & Welfare Fund v. Morristown Memorial Hosp.*, 995 F.2d 1179, 1193 (3rd Cir.) (state statute may be preempted if statute's effect is to "dictate or restrict the choices of ERISA plans with regard to their benefits, structure, [or] reporting and administration"), *cert. denied*, 510 U.S. 944 (1993). "By preventing states from imposing divergent obligations, ERISA allows each employer to create its own uniform plan, complying with only one set of rules (those of ERISA) and capable of applying uniformly in all jurisdictions where the employer might operate." *Rosario-Cordero v. Crowley Towing & Transp. Co.*, 46 F.3d 120, 123 (1st Cir. 1995).

> Congress intended 'to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government. . ., [and to prevent] the potential for conflict in substantive law ... requiring the tailoring of plans and

> employer conduct to the peculiarities of the law of each jurisdiction.

New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. v. Co., 514 U.S. 645, 656-57 (1995) (quoting *Ingersoll-Rand*, 498 U.S. at 142).

In response, Defendant maintains that the AWP law does not have a "connection with" ERISA because the Kentucky statute is a law of general applicability in an area traditionally regulated by the state and has only an indirect economic effect on ERISA plans. Moreover, Defendant argues, the statute does not bind plan administrators to a particular choice regarding the core administrative functions and responsibilities of ERISA plans. To support this argument, Defendant relies primarily on more recent Supreme Court pronouncements which define the "outer limits" of ERISA preemption. The "recent Supreme Court pronouncements recognize the impossibility of extracting meaningful limits from the statutory language alone, and reject such 'uncritical literalism' in favor of analyzing 'the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive'... [t]hese opinions also recognize the importance of analyzing the purposes of the challenged legislation and the nature of the effect of such legislation on ERISA plans." *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F. Supp. 60 (D. Mass. 1997).

In *Travelers*, 514 U.S. at 650, the Supreme Court considered whether ERISA preempted a New York statute which required hospitals to collect surcharges from patients whose services were reimbursed by commercial health insurance and which also required HMOs to pay varying surcharges based on their number of Medicaid members. The purpose of the statute was to raise the cost of commercial insurance for carriers other than Blue Cross and Blue Shield, and to shift market shares back to economically threatened Blue Cross and Blue Shield plans. *Id.* at 658-59. The Supreme Court rejected that the statute directly affected plan benefits or administra-

tion. Rather, the Court's focus was on whether the statute indirectly affected the economic choices made by plan administrators to such an extent as to trigger preemption. *Id.* at 659.

In holding the statute not preempted, the Supreme Court reiterated that "[p]reemption does not occur ... if the state law has only a tenuous, remote, or peripheral connection with covered plans, as is the case with many laws of general applicability." *Id.* at 661 (quoting *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 129 n.1 (1992). The Court also noted that "nothing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation," and that "laws with only an indirect economic effect on the relative costs of various health insurance packages... are a far cry from those 'conflicting directives' from which Congress meant to insulate ERISA plans. *Id.* at 661-62.

Even more recently, the Supreme Court rendered two decisions further expounding on the *Travelers* rationale. In *California Division of Labor Standards Enforcement v. Dillingham Constr.*, __U.S. __, 117 S.Ct. 832 (1997), the Supreme Court held that a California "prevailing wage" statute, which had the effect of regulating an apprenticeship plan that was an employee welfare benefit plan, did not "relate to" employee benefit plans within the meanings of ERISA. As in *Travelers*, the Court looked to the objectives of ERISA and the nature and effect of the state law on ERISA plans. *Id.* at 840-842. Again, the Court's analysis started with the assumption that the historic police powers of the state would not be superseded absent clear indication that was Congress' intent. *Id.* at 840. The Court found that the indirect influence of the surcharge did not "preclude uniform administrative practices or the provision of a uniform interstate benefit package if a plan wished to provide one." *Id.*

In *DeBuono v. NYSA-ILA Medical & Clinical Services Fund*, ___ U.S. ___ 117 S.Ct. 1747 (1997), the Supreme Court held that ERISA did not preempt New York from im-

posing a gross receipts tax on medical centers which were owned and operated by an ERISA-covered employee benefit plan. The Court held that the New York law did not "dictate the choices facing... ERISA plans." *Id.* at 1752. Rather, the Supreme Court found that the statute was "one of 'myriad state laws' of general applicability that impose some burdens on the administration of ERISA plans but nevertheless do not 'relate to' them within the meaning of [ERISA]." *Id.*

The Court finds it significant that these recent cases defining the "outer limits" of ERISA preemption clearly establish that the Supreme Court has not disavowed its earlier decisions. As previously noted, in reaching its decision in *Travelers*, the Supreme Court distinguished the surcharge statute from the mandated benefit laws at issue in *Metropolitan Life* and from laws which preclude uniform administrative practices of ERISA plans. *Id.* at 657-58, 662-63. Based on this fact, the issue presently before the Court appears to rest on whether Kentucky's AWP law can be likened to a mandated benefit law or a law which affects uniform plan administration, or whether it is more akin to the statutes at issue in *Travelers*, *Dillingham* and *DeBuono* -- statutes of general applicability with only an indirect economic effect on employee benefit plans.

The only published post-*Dillingham* and *DeBuono* case involving an any willing provider law is *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F. SUPP. 60 (D. Mass. 1997). In *American Drug*, the district court held that a state AWP law prohibiting the formation of restricted pharmacy networks did not "relate to" ERISA.[6] *Id.* at 69. In reaching its decision, the court rejected the defendants' argument that the statute "mandates employee benefit

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[6] The Massachusetts statute precluded an insurance carrier from "[imposing any agreements terms or conditions on any non-network...which are more restrictive than those required of any pharmacy in the carrier's restricted pharmacy network." *Id.* at 61.

structures or administration." In this regard, the court noted that "[there] is no question that the Act's mandates are not directly applicable to ERISA plans, that is ERISA plans are not 'carriers' and so may themselves offer pharmacy networks without complying with the Act's requirements." *Id.*

Dismissing the argument that the AWP statute mandated benefits or plan administration, the *American Drug* court then proceeded with a *Travelers/Dillingham/DeBuono* type analysis. The court started with the presumption that Congress did not intend to supplant the AWP law because the law fell within an area of traditional state regulation -- the health care and insurance industries. *Id.* at 65. The court also compared the objectives of ERISA with those of the state law to see if the state law frustrated ERISA's goal to "avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Id.* at 66 (quoting *Travelers*, 514 U.S. at 657.

The *American Drug* court noted that the Massachusetts law "in no way interferes with eligibility determinations, benefit calculations, disbursements, fund monitoring or recordkeeping." *Id.* at 67. The court also noted that "the establishment and operation of provider networks [does not] seem the type of activity which could become 'nationally uniform' absent state interference. Selection of providers is inherently a local matter which involves a variety of regional factors, and it can hardly be expected that it could achieve the same national uniformity as standards for processing claims or making disbursements." *Id.* Moreover, the court noted that selection of provider networks is not a traditional function of ERISA plans, and "surely was not a function Congress contemplated in enacting ERISA." *Id.* The *American Drug* Court concluded that the involvement of ERISA plans in such activities as the establishment and operation of provider networks should not extend the scope of ERISA. *Id.*

In the present case, despite the fact that the Court wholeheartedly agrees with *American Drug*'s position that not

every law affecting plan administration merits preemption, the Court rejects Plaintiffs' argument that Kentucky's AWP does not have a "connection with," and therefore does not "relate to," employee health benefit plans. The Court bases this decision primarily on its belief that the AWP law is more akin to the mandated benefits law at issue in *Metropolitan Life* than to the statutes of general applicability at issue in *Travelers*, *Dillingham* and *DeBuono*. By restricting risk-bearing entities from offering health benefit plans with restricted provider networks, the AWP law effectively mandates the benefit structure of employee benefit plans. Under *Metropolitan Life*, this "mandated benefit" is sufficient to support that Kentucky's AWP statute has a "connection" with employee benefit plans sufficient to trigger preemption.

Initially, the Court relies on dicta in *Metropolitan Life* which refers to mandated provider laws as a type of mandated benefit law regulating the substantive terms of insurance policies. *Id.* at 729; *see also Stuart Circle*, 995 F.2d 500, 504 (4th Cir) (same), *cert. denied*, 510 U.S. 1003 (1993). Mandated provider laws require insurers to pay for the services of a particular type of health care provider, even if the terms of the policy provide that payment will be made only to another type of provider. For instance, a typical mandated provider law may provide that, if an insurance policy provides for reimbursement of visual services, an insured entitled to reimbursement under such policy is entitled to reimbursement regardless whether such services are performed by a duly licensed physician or by a duly licensed optometrist. States have enacted these statutes to give insured's freedom of choice to seek the services of podiatrist, chiropractors, osteopaths, occupational therapists and nurse midwives, among others. *See generally* Larry J. Pittman, *"Any Willing Provider" Laws and ERISA's Saving Clause: A New Solution For An Old Problem*, 64 Tenn. L. Rev. 409, 452 & nn. 189-90 (1997).

Under the circumstances, the Court finds little practical difference between mandated provider laws and any-willing provider laws:

> A mandated provider law affirmatively mandates that insurers pay specified providers at the same reimbursement as preferred providers despite the non-preferred status of those specified providers. An any willing provider law requires that preferred status be granted to any provider willing to meet specified terms and conditions. The end result of both types of laws is that the insurer must pay certain providers who are nonpreferred at the same rate as preferred providers. Consequently, the two types of laws are basically the same... In other words, since both types of laws require that nonpreferred providers be paid at the same rate as preferred providers, it really does not matter whether the nonpreferred provider is a member of the provider list under an any willing provider law or a nonmember under a mandated provider law.

Id. at 453 n.190. As a result of this similarity, Professor Pittman articulates that the dicta in *Metropolitan Life* is strong support for the argument that AWP statutes regulate the substantive terms of insurance policies in the same way as mandated provider laws. *Id.* at 452-53.

Moreover, in its ERISA "relates to" analysis, the Sixth Circuit has looked at whether an allegedly offending statute affects or regulates the relationship between the traditional ERISA entities -- the plan, the employer, the plan fiduciaries and the plan beneficiaries. *Thiokol Corp. v. Roberts*, 76 F.3d 751, 755 (6th Cir. 1996), *cert. denied*, 117 S.Ct. 2448 (1997). Arguably, the state laws at issue in *Travelers*, *Dillingham* and *DeBuono* did not regulate the relationship between the traditional ERISA entities. Rather, those laws were laws of general applicability not specifically designed to affect the relationship between the plan, the employer, plan fiduciaries and plan beneficiaries. On the other hand, Kentucky's AWP law

regulates the relationship between the principal ERISA entities. By regulating the contracts or "plans" offered by risk-bearing entities, the statute effectively precludes employers with insured ERISA plans from restricting provider networks. This, in turn, enables plan beneficiaries to exercise greater freedom of choice in selecting a provider.

From a practical standpoint, freedom of choice in selecting a personal physician is as important to many insureds as are the policy terms relating to coverage and costs. In this regard, the AWP law differs from general health care regulation regarding provider certification or from general state contract, zoning or tort legislation. Although Kentucky's AWP law does not give plan beneficiaries a *per se* right to select the physician of his or her own choice, the statute does effectively preclude insurer's from arbitrarily limiting provider panels to those providers preferred by the insurer. Thus, the AWP law is aimed at giving insureds greater freedom of choice in selecting a physician. Any law which affects so fundamentally an insureds' ability to select a health care provider of his or her own choice has more than merely an indirect economic effect on the administrative choices of plan administrators. In this respect, the Court notes a qualitative difference between Kentucky's AWP law and the surcharge held not preempted in *Travelers*, the "prevailing wage" law held not preempted in *Dillingham* and the gross receipts tax held not preempted in *DeBuono*: the latter truly are laws of general applicability, while the former focuses directly on the relationship between the insurer and the insured.[7]

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[7] Interestingly, the *American Drug* court recognized that the Massachusetts' AWP law was "an integral part of the relationship between the insurer and insured because it affects the substantive terms of the policy by broadening the range of providers that an insured may chose." *Id.* at 71. Under the circumstances, it seems to some extent contradictory to find that an AWP law fundamentally affects the substantive terms of the policy between the insurer

Based on the foregoing, the Court sees no difference between the Kentucky AWP statute and the mandated benefits law in *Metropolitan Life*. Kentucky's AWP statute effectively precludes insured ERISA plans from utilizing restricted provider networks. Under the holding of *Metropolitan Life*, the statute thus impermissibly regulates the substantive terms of the plan that an insured ERISA plan can offer its participants. By so doing, the statute bears "indirectly but substantially" on all insured plans. For this reason, the Court holds that Kentucky's AWP statute "relates to" ERISA.

2. "Saving" Clause Analysis

Having concluded that Kentucky's AWP" law "relates to" ERISA, it is preempted unless saved by the savings clause. As previously mentioned, ERISA's saving clause expressly exempts from preemption any state law "which regulates insurance." 29 U.S.C. 1144(b)(2)(A). In *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740-43 (1985), the Supreme Court articulated a two-prong test for determining whether a law "regulates insurance" within the meaning of the saving clause. First, the Court considered whether the law fit a common-sense definition of insurance regulation. *Id.* at 740-42. Second, the Court considered three criteria taken from case law interpreting the phrase "business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011 - 15:

> [F]irst, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry.

Id. at 743.

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and insured but that the law does not impact the structure of or have a "connection with" employee health benefit plans.

There is a split of authority among courts which have considered whether a state AWP law is "saved" from preemption as a law which "regulates insurance." The Court notes, however, that some of the AWP laws held not "saved" are distinguishable based on their wording. Furthermore, unlike other circuits, the Sixth Circuit has held that it is not necessary for a law to satisfy all three of the McCarran-Ferguson factors in order to be found a law which regulates insurance. *See Davies v. Centennial Life Ins. Co.*, 128 F.3d 934, 940 (6th Cir. 1997); *accord Cisneros v. UNUM Life Ins. Co.*, 134 F.3d 939, 946 (9th Cir. 1998) (determining that the McCarran-Ferguson factors are "simply relevant considerations or, guideposts. not essential elements of a three-part test that must each be satisfied for a law to escape preemption.") *Id.* The Court's decision is also influenced by the fact that the AWP statute does not *clearly fail* any of the relevant criteria. With the foregoing in mind, it is this Court's opinion that Kentucky's AWP statute is one of those broad category of laws which "regulate insurance" and thus falls within the scope of the "saving" clause.

a. Common sense test

To satisfy the common sense test, "a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987) (holding that common law action resulting from bad faith refusal to pay a claim did not pass common sense" test because the action evolved from general principles of contract and tort law); *see also Williams v. Ashland Engineering Co., Inc.*, 45 F.3d 588, 592 (1st Cir. 1995) (concluding that law whose "impact on the insurance industry [was] happenstance" was not directed toward business of insurance.

Plaintiffs maintain that the AWP statute does not pass the common sense test because it is not aimed at the relationship between the insurance company and the policyholder; rather, Plaintiffs argue, the AWP law focuses solely on the relation-

ship between health benefit plans and health care providers. Plaintiffs also argue that the Kentucky statute does not meet the common sense test because, by its express terms, the statute affects self-insured plans and MEWAs and, therefore, is not specifically limited to the insurance industry.[8]

Defendant argues that the AWP law passes the common sense test because the law *is* specifically directed toward the insurance industry. The Court agrees. To begin with, the Court rejects that the AWP law is focused on the relationship between health benefit plans and health care providers. The statute establishes that certain plans or contracts through which the regulated entities assume financial risk cannot include restricted provider networks. Therefore, although the statute affects the relationship between insurers and providers, its focus appears to be on the contractual relationship between the insurer and the policyholder. The statute affects specific terms of the insurance policies. *See International Resources v. New York Life Ins. Co.*, 950 F.2d 294, 300 (6th Cir. 1991) (statute satisfies common sense test where it affects specific terms of the insurance policy), *cert. denied*, 504 U.S. 973 (1992). The Court finds this fact, as a matter of common sense, sufficient to establish that the AWP regulates insurance

Furthermore, the AWP law is located in KRS Chapter 304, which constitutes the Kentucky Insurance Code. *See Stuart Circle Hospital Corp. v. Aetna Health Management*, 995 F.2d 500, 503 (4th Cir.) (Virginia's AWP law satisfies "common sense" test because it is part of state's comprehensive insurance code), *cert. denied*, 510 U. S. 1003 (1993). Other than traditional insurance companies, the entities regulated by Kentucky's AWP include 1) HMOs, which are required to get a certificate of authority in KRS 304.38-035; 2)

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[8] As previously mentioned, the Court rejects that the AWP statute applies both to self-insured plans or plans provided by a MEWA. By its plain terms, the statute is applicable to these entities only "to the extent permitted by ERISA."

provider-sponsored integrated health delivery networks, which are required to obtain certification pursuant to KRS 304.17A-300; and 3) MEWAs, which ERISA specifically does not exempt from state insurance laws to the extent those state laws do not conflict with ERISA. Each of these entities is regulated by the Kentucky Department of Insurance. Moreover, the regulated entities are recognized as "insurers or insurer-related entities which, for a fee, assume the risk entailed in ensuring that their customers receive health care." *American Drug*, 973 F. Supp. at 70.

Finally, in *Metropolitan Life*, 471 U.S. at 740, the Supreme Court applied the "common sense" test in a cursory fashion, merely noting that "[t]o state the obvious, [the mandated mental health benefits law] regulates the terms of certain insurance contracts, and so seems to be saved from preemption by the saving clause as a law 'which regulates insurance.'" The summary nature of the Court's analysis and the fact that this is a "common sense" test supports that this is not a determination requiring a formalistic approach. *See also FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990) (holding that state law precluding insurers from creating a right to subrogation against a claimant's tort recovery passed common sense test because it was "aimed at" insurance industry).

b. Transferring or Spreading of Risk

The Supreme Court has explained that the term "risk," as used here, refers to the risk of injury for which the insurance company contractually agreed to compensate the insured. *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 130 (1982). Plaintiffs maintain that Kentucky's AWP law does not affect the initial apportionment of risk at the inception of the insurance contract. Instead, Plaintiffs argue, the AWP law affects only who must be able to provide services to the insured *after* the risk has been spread.

Defendant, on the other hand, relies primarily on *Stuart Circle Hospital Corp. v. Aetna Health Management*, 995 F.2d 500, 503-04 (4th Cir. 1993), where the court held that a state

AWP statute has a sufficient effect on the spreading of risk to satisfy the *Metropolitan Life* test:

> If [an insurance company] unreasonably restricts the providers of treatment, even though they meet the insurer's standards, it denies an insured the choice of doctor... that may best suit the insured's needs, unless the insured is willing and able to pay all or part of the cost of the doctor or hospital that is not preferred by the insurer. This is a restriction of the insured's benefits. By its prohibition against unreasonable restriction of providers, the Virginia statute spreads the cost component of the policyholder's risk among all the insureds, instead of requiring the policyholder to shoulder all or part of this cost when seeking care or treatment from an excluded doctor... of his or her own choice.... [T]he statute indirectly affects the insured's choice of provider and the consequent cost to the insured if he or she deems an excluded provider to be better qualified for treatment of a specific illness or accident. In this way it affects the risk that an insured must bear.

The Court agrees with this rationale. Insurance contracts containing "preferred provider" provisions commonly reimburse insureds -- by using higher deductibles and/or copayments -- at a lower percentage rate for using a provider not on the preferred list. Allowing some insureds to receive treatment from providers not originally on the preferred provider list transfers some of the cost component of the insured's risk to the insurer. In this respect, Kentucky's AWP law is akin to the mandated benefits law in *Metropolitan Life*. Although the statute in *Metropolitan Life* altered the substantive scope of coverage, whereas Kentucky's AWP statute alters a cost component relating to coverage, both statutes effectively transfer some degree of financial risk from the insured to the insurer. *See Texas Pharmacy Ass'n v. Prudential Ins. Co.*, 105 F. 3d 1035, 1041 (5th Cir.) (prior version of statute affects spreading of risk because it "influenced which costs

were ultimately borne by the insurer and which were borne by the beneficiary), *cert. denied*, 118 S.Ct. 75 (1997); *American Drug*, 973 F. Supp. at 71 (statute affects spreading of risk "because, by enabling insureds to fill their prescriptions at additional pharmacies, it transfers some of the cost of treatment -- which is the risk insured against -- from the insured to the carrier").

c. Integral Part of Relationship Between the Insurer and the Insured

In *Metropolitan Life*, 471 U.S. at 743, the Supreme Court articulated that mandated-benefit statutes affect the relationship between the insurer and the insured. By imposing "requirements only on insurers, with the intent of affecting the relationship between the insurer and the policyholder,. . . [mandated benefit statutes relate] to the regulation of the business of insurance as defined in the McCarran-Ferguson Act." *Id.*

> Congress was concerned [in the McCarran-Ferguson Act] with the type of state regulation that centers around the contract of insurance. . . . The relationship between insurer and insured, *the type of policy which could be issued*, its reliability, interpretation, and enforcement -- these were the core of the 'business of insurance.' [T]he focus [of the statutory term] was on the relationship between the insurance company and the policyholder. Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the 'business of insurance.' [Emphasis in original]

Id. at 743-44 (Emphasis added) (quoting *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969)).

By requiring insurers to accept on their panel any provider willing to accept the terms for participation, Kentucky's AWP statute effectively dictates a substantive term in the contract between the insurer and the insured and, as a result, is integral

to that relationship. *See Stuart Circle*, 995 F.2d at 503 ("[T]reatment and cost are important components of health insurance. Regulations governing these components... are integral parts of the relationship between insurer and insured.")

d. Limited to Entities Within the Insurance Industry

As previously discussed, Kentucky's AWP regulates traditional insurance companies as well as HMOs, provider-sponsored integrated health delivery networks and MEWAs. Each of these entities is regulated by the Kentucky Department of Insurance. For a fee, each of these entities accepts the risk and responsibility of providing health care benefits to member- insureds. Whatever difference in form or structure that exists as between traditional insurance companies and HMOs, MEWAs, and provider-sponsored integrated health delivery networks is insufficient to establish that Kentucky's AWP law is not limited to entities within the insurance industry. To hold otherwise would require the Court to recognize form over substance and to refuse to recognize the natural evolution of the health insurance industry. *Cf. SEC v. Variable Annuity Life Ins. Co.*, 359 U.S. 65, 71 (1959) ("We realize that life insurance is an evolving institution. Common knowledge tells us that the forms have greatly changed even in a generation. And we would not undertake to freeze the concepts of "insurance". . . into the mold they fitted when these Federal Acts were passed.")

On balance, the Court believes that Kentucky's AWP statute is a law properly saved from ERISA preemption. In reaching this decision, the Court recognizes Plaintiffs' argument that the "saving" clause factors should be applied narrowly in accordance with the Supreme Court's analysis in *Group Health Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979) The Court, however, finds the present circumstances distinguishable from those in *Royal Drug*.

Royal Drug concerned an antitrust challenge by independent pharmacies to Blue Shield's practice requiring participating pharmacies to accept a $2 payment from insureds

and be reimbursed for the remainder of the cost by Blue Shield. Unlike the present case, Blue Shield's policy essentially did not concern policyholders because it did not affect their ability to obtain reimbursement. *American Drug*, 973 F. Supp. at 71. The focus was on the agreement between Blue Shield and participating pharmacies and whether this agreement was part of the business of insurance. *Id.* Because policyholders were basically unaffected by the agreement, the challenged policy clearly did not affect the transfer of risk. *Id.*

In the present case, however, the AWP does affect the ability of policyholders to obtain reimbursement. There is evidence in the record that certain providers have requested admission to health benefit plans from which they have been excluded. If the excluded doctors are admitted to these plans pursuant to the AWP statute, patients who seek treatment from them will be reimbursed at a different rate. Broadening the provider network shifts certain costs of treatment from the insured to the insurer.

Notably, the *Royal Drug* Court "emphasized that 'quite different' questions are raised by the McCarran-Ferguson Act's exemption of the business of insurance from antitrust laws and by its preservation of state regulation of the activities of insurance companies." *See American Drug*, 973 F. Supp. at 72 (citing *Royal Drug*, 440 U.S. at 218 n. 18 (explaining that the McCarran-Ferguson Act broadly preserves the business of insurance for state regulation while narrowly exempting only "the business of insurance" from the antitrust laws).

Moreover, commentators have suggested that the recent Supreme Court decision in *United States v. Fabe*, 508 U.S. 491 (1993),[9] also supports a less narrow application of the

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[9] In *Fabe*, the Supreme Court considered whether a federal priority statute giving the United States first priority preempted a state statute giving the United States fifth priority to the assets of a

savings clause in the ERISA context. See *generally* Karen A. Jordan, *ERISA Pre-Emption: Integrating Fabe into the Savings Clause*, 27 Rutgers L.J. 273) (1996); *"Any Willing Provider" Laws and ERISA's Saving Clause: A New Solution for an Old Problem*, 64 Tenn. L. Rev. 409 (1997). Although *Fabe* is not an ERISA case and courts generally have not applied its holding in the ERISA context,[10] it does reiterate the Supreme Court's statements in *Royal Drug* and arguably suggests that the Court's present analysis, which involves a state insurance regulation, is not an overly broad application of the McCarran-Ferguson criteria.

The Court having thoroughly reviewed the matter, having set forth its views above, and being otherwise sufficiently advised,

IT IS HEREBY ORDERED:

1. That the Motion for Summary Judgment by Plaintiffs, Community Health Partner's Inc. and Reservoir Health Services, Inc. d/b/a Center Care, is **denied**; and

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bankrupt insurance company. *Id.* at 495-96. The Court held the federal statute preempted to the extent the state law protected the interests of policyholders. *Id.* at 506. In reaching its decision, the Court focused on the meaning of the phrase "business of insurance" as used in the McCarran-Ferguson Act. *Id.* at 505. The Court articulated that, by its express language, the McCarran-Ferguson Act broadly reserves to the States the power to enact laws "for the purpose of regulating the business of insurance," while narrowly exempting from federal antitrust laws only those laws constituting the "business of insurance." *Id.*

[10] In *Prudential Ins. Co. v. National Park Medical Ctr.*, 964 F. Supp. 1285, 1299 (E.D. Ark. 1997), the court rejected the defendants argument that Fabe replaces the test for the "business of insurance." In *Franklin H. Williams Ins. Trust v. Travelers Ins. Co.*, 50 F.3d 144, 151 (2nd Cir. 1995), the appellate court noted that "Fabe, although not an ERISA case, makes clear that the [Supreme Court] continues to grant considerable deference to state regulation of insurance."

2. That the Motion for Summary Judgment by Defendant, Commonwealth of Kentucky ex rel. George Nichols III, Commissioner of Insurance is **granted**.

THIS IS A FINAL AND APPEALABLE ORDER AND THERE IS NO JUST CAUSE FOR DELAY.

This 2nd day of June, 1998.

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Joseph H. McKinley, Jr.

Judge, United States District Court

cc: Counsel of Record

FILED
NOV. 13 2000
LEONARD GREEN, CLERK

COMMUNITY HEALTH PARTNERS. INC., ET AL.,
Plaintiffs-Appellants,
v.
COMMONWEALTH OF KENTUCKY, ET AL.,
Defendants-Appellees.
No. 98-5941

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

BEFORE: KENNEDY and NORRIS, Circuit Judges; and HOLSCHUH,[1] District Judge.

ORDER

The court having received a petition for rehearing en banc, and the petition having been circulated not only to the original panel members but also to all other active judges of this court, and no judge of this court having requested a vote on the suggestion for rehearing en banc, the petition for rehearing has been referred to the original panel.

The panel has further reviewed the petition for rehearing and concludes that the issues raised in the petition were fully considered upon the original submission and decision of the case. Accordingly, the petition is denied.

ENTERED BY ORDER OF THE COURT

Leonard Green, Clerk

[1] Hon. John D. Holschuh, Senior United States District Judge for the Southern District of Ohio, sitting by designation.

Kentucky Association of Health Plans, Inc.; Advantage Care,Inc.; Aetna Health Plans of Ohio, Inc.; Choicecare Health Plans, Inc.; FHP of Ohio, Inc.; HMPK, Inc.; HPLAN, Inc.; Humana Health Plan, Inc.,
Plaintiffs-Appellants,
v.
George Nichols, III, in his official capacity as Commissioner of the Kentucky Department of Insurance,
Defendant-Appellee.

No. 98-6308

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

Argued: September 20, 1999
Decided and Filed: September 7, 2000

HOLSCHUH, District Judge. Plaintiffs are seven health maintenance organizations (HMOs) licensed under the laws of Kentucky, and the Kentucky Association of Health Plans, Inc., a non-profit association organized to promote the business interest of its HMO members (hereinafter referred to as "plaintiffs"). Plaintiffs filed this action against George Nichols III ("defendant"), in his official capacity as Commissioner of the Kentucky Department of Insurance. Plaintiffs argued that Kentucky Revised Statutes Annotated §§ 304.17A-110(3) and 304.17A-171(1)-(8) (Banks-Baldwin 1995), should be found preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), and sought injunctive relief from their enforcement. Both parties moved for summary judgment. The district court denied plaintiffs' request for summary judgment and granted defendant's cross-motion for summary judgment, concluding that §§ 304.17A-110(3) and 304.17A-171(2) were saved from preemption by ERISA because they "regulated insurance" under ERISA's savings

clause. Plaintiffs assert that the district court erred in this conclusion.

I. The State Statutes

In 1994, the Kentucky General Assembly enacted the Kentucky Health Care Reform Act (the "Act"). The Act contained an "Any Willing Provider" provision that stated: "Health care benefit plans shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and is willing to meet the terms and conditions for participation established by the health benefit plan." Ky. Rev. Stat. Ann. § 304.17A-110(3) (Banks-Baldwin 1995). The Act defined a health benefit plan as:

> [Any] hospital or medical expense policy or certificate; nonprofit hospital, medical-surgical, and health service corporation contract or certificate; a self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA; health maintenance organization contract; and standard and supplemental health benefit plan as established in KRS 304.17A-160. § 304.17A-100(4)(a) (Banks Baldwin 1995).

In 1996, the Kentucky General Assembly added §§ 304.17A-170 and 171 to the code. The additions specifically regulate how "health benefit plans" can interact with chiropractors.[1] Not only does the statute contain an "any willing

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[1] Section 304.17A-170(1) states that "health benefit plan" has the same meaning as in § 304.17A-005, which provides in pertinent part:

> "Health benefit plan" means any hospital or medical expense policy or certificate; nonprofit hospital, medical-surgical, and health service corporation contract or certificate; provider sponsored integrated health delivery network; a self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA; health mainte-

provider" provision addressed particularly to chiropractors,[2] but it also imposes various additional requirements on health benefit plans that include chiropractic benefits.[3] See § 304.17A-171.

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nance organization contract; or any health benefit plan that affects the rights of a Kentucky insured and bears a reasonable relation to Kentucky, whether delivered or issued for delivery in Kentucky . . . .

§ 304.17A-005(17) (Banks Baldwin 1999).

[2] The "any willing provider" provision of § 304.17A-171(2) states:

A health benefit plan that includes chiropractic benefits shall:

(2) Permit any licensed chiropractor who agrees to abide by the terms, conditions, reimbursement rates, and standards of quality of the health benefit plan to serve as a participating primary chiropractic provider to any person covered by the plan.

[3] Specifically, health benefit plans are required to: include all primary chiropractic providers who are selected by a person covered by the plan; allow participants direct access to chiropractors of their choice without referral from a gatekeeper; appoint a chiropractor as a gatekeeper for the provision of chiropractic services when the plan uses gatekeepers; refrain from discriminating in reimbursement rates between chiropractors; refrain from promoting or recommending any chiropractor to a covered person; assure adequate numbers of providers are included in the plan; and make listings of participating chiropractors available to covered persons on a regular basis. § 304.17A-171(1) & (3)-(8).

The district court apparently limited its analysis to Kentucky's "Any Willing Provider" provisions, the general provision being located at § 304.17A-110(3) and the specific chiropractic provision being located at § 304.17A-171(2). The district court noted that the chiropractic statute imposed additional requirements, beyond those imposed by the general "any willing provider" statute, but because both statutes "similarly define 'health benefit plan'" the court referred to those statutes collectively. J.A. at 35. Because the court never explicitly addressed provisions (1) and (3)-(8) of § 304.17A-

In April of 1997, plaintiffs filed suit in the Eastern District of Kentucky, requesting that § 304.17A-110(3) and § 304.17A-171 (for convenience we will collectively refer to § 304.17A-110(3) and § 304.17A-171(2) as Kentucky's "AWP" laws) be declared, among other things, preempted by § 514(a) of ERISA, 29 U.S.C. § 1144(a). Plaintiffs moved for partial summary judgment on the issue and Commissioner Nichols cross-moved for partial summary judgment as well. The district court determined that while the Kentucky AWP laws were related to employee benefit plans under ERISA § 514(a), they regulated the business of insurance and therefore fell under the saving clause of § 514(b), 29 U.S.C. § 1144(b)(2)(A). The court thus granted partial summary judgment in favor of Commissioner Nichols and determined its order to be final and appealable. This appeal followed.

Sections 304.17A-110(3) and 304.17A-100(4)(a) were repealed by the Kentucky legislature effective July 1, 1999. The parties acknowledge that this appeal is not moot, however, as the legislature, through House Bill No. 315 (Ky. 1998), replaced the repealed provisions with the same requirements, but substituted the term "health insurer" for "health benefit plan" in its any willing provider provision, now located at Kentucky Revised Statutes Annotated § 304.17A-270 (Banks-Baldwin 1999). The Bill's definition of "insurer" was codified at Kentucky Revised Statutes Annotated § 304.17A-005(22) (Banks-Baldwin 1999), which defines "insurer" as:

> [A]ny insurance company; health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider- sponsored integrated health delivery network; self-insured employer-organized association, or nonprofit hospital, medical-surgical, dental, or health serv-

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171, the chiropractic statute, we will remand the issue of their preemption for consideration in the first instance by the district court.

> ice corporation authorized to transact health insurance business in Kentucky.

The parties having agreed that this appeal is not rendered moot by the new language used in the present statutes, the court will consider the AWP laws in their present form in the court's analysis of their validity, rather than adjudicating the validity of repealed statutes.

The chiropractic provisions contained in § 304.17A-171 and § 304.17A-170 were left intact by House Bill No. 315 and continue to remain unchanged.

The issue of the potential preemption of §§ 304.17A-270 and 304.17A-171(2) by ERISA is therefore properly before this court.[4] We review a district court's decision to grant summary judgment de novo, applying the same test as that employed by the district court. Wathen v. General Elec. Co., 115 F.3d 400, 403 (6th Cir. 1997). Summary judgment is proper if there is no genuine issue of material fact and the moving party is entitled to a judgment as a matter of law. See Schachner v. Blue Cross & Blue Shield of Ohio, 77 F.3d 889, 892-93 (6th Cir. 1996).

II. Preemption

We are required by this appeal to define the boundaries of preemption under ERISA § 514 (a) and (b), 29 U.S.C. § 1144(a) and (b). Section 514(a), the preemption provision, reads:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as

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[4] The appeal taken from Community Health Partners v. Commonwealth of Kentucky, 14 F. Supp. 2d 991 (W.D. Ky. 1998), raised the question of whether § 304.17A-110(3) (replaced by § 304.17A-270) was preempted under ERISA and was argued the same day as this case. As a result, this opinion will necessarily dictate the outcome of that case as well.

> they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title (emphasis added).

Section 514(b)(2)(A), the "savings" provision, reads:

> Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities.

Section 514(b)(2)(B), the "deemer" provision, reads:

> Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

The federal courts have addressed the scope of ERISA's preemption of State law on numerous occasions; however, the wording of the Act combined with the obvious federalism concerns involved have made it difficult to discern clear boundaries. Many courts, including the Supreme Court, have commented on the vexingly broad and ambiguous nature of the provisions.[5] Despite such interpretational difficulties, we

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[5] *See, e.g., California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 335-36, 117 S. Ct. 832, 843, 136 L. Ed. 2d 791, 805-06 (1997) (Scalia, J., concurring) (noting that the Court had taken 14 previous cases regarding ERISA preemption, and suggesting that neither the Court's prior decisions, nor its present one, succeeded in bringing clarity to the

must determine whether Kentucky Revised Statutes Annotated §§ 304.17A-270 and 304.17A-171(2) (Banks-Baldwin 1999) "relate to" employee benefit plans covered by ERISA. If so, then the provisions are preempted, unless they fall under ERISA's saving clause as laws regulating insurance.

ERISA is a comprehensive act designed to regulate employee welfare and pension benefit plans, including those that provide "'medical, surgical, or hospital care or benefits' for plan participants or their beneficiaries 'through the purchase of insurance or otherwise.'" *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 650-51, 115 S. Ct. 1671, 1674, 131 L. Ed. 2d 695, 702 (1995) (discussing and quoting ERISA § 3(1), 29 U.S.C. § 1002(1)). To assure that the regulation of employee welfare benefits would remain an area of exclusive federal concern, Congress passed § 514(a) of ERISA, the preemption provision.

The Supreme Court has specifically found that in passing § 514(a) it was Congress' intent:

> to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or

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law); *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656, 115 S. Ct. 1671, 1677, 131 L. Ed. 2d 695, 705 (1995) (remarking on the unhelpful nature of the statute's text and the frustrating difficulty of defining its key terms); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739, 105 S. Ct. 2380, 2389, 85 L. Ed. 2d 728, 740 (1985) (observing that the provisions were "not a model of legislative drafting"); *Prudential Ins. Co. of Am. v. National Park Med. Ctr., Inc.*, 154 F.3d 812, 818 (8th Cir. 1998) (comparing efforts to discern the scope of ERISA preemption to unraveling the fabled Gordian knot).

> between States and the Federal Government . . ., [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.

Travelers, 514 U.S. at 656-57, 115 S. Ct. at 1677, 131 L. Ed. 2d at 706 (alteration in original) (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142, 111 S. Ct. 478, 484, 112 L. Ed. 2d 474, 486 (1990)). In discussing the preemption provision, the Court has variously noted its extreme breadth, terming it "clearly expansive," "broad [in] scope," "broadly worded," "deliberately expansive," and "conspicuous for its breadth." *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 324, 117 S. Ct. 832, 837, 136 L. Ed. 2d 791, 799 (1997) (internal citations omitted) (reviewing past Supreme Court case law addressing the scope of ERISA's preemption provision). The preemption provision, however, is not without limits. As the Court noted in *Travelers*, § 514(a) preempts all state laws that relate to an employee benefit plan covered by ERISA, but, "if 'relate to' were taken to extend to the furthest stretch of its indeterminancy, then for all practical purposes preemption would never run its course." 514 U.S. at 655, 115 S. Ct. at 1677, 131 L. Ed. 2d at 705.

Thus, to determine whether a law "relates to" an employee benefit plan, the Court has formulated a two part test, under which a "law 'relate[s] to' a covered employee benefit plan for purposes of § 514(a) if it [1] has a *connection with* or [2] *reference to* such plan." *Dillingham*, 519 U.S. at 324, 117 S. Ct. at 837, 136 L. Ed. 2d at 799 (internal quotations and citations omitted) (emphasis added). The district court found, and plaintiffs argue, that the Kentucky AWP provisions both refer to and have a connection with ERISA covered employee

benefit plans.[6] We analyze each prong of the "relation to" test in turn.

A. Reference To

The Supreme Court has provided guidance in several cases as to when a law "refers to" ERISA. In *Dillingham* the Court summarized its analysis, stating:

> [W]e have held preempted a law that "impos[ed] requirements by reference to [ERISA]," *District of Columbia v. Washington Bd. of Trade*, 506 U.S. 125, 130-31, 121 L. Ed. 2d 513, 113 S. Ct. 580 (1992); a law that specifically exempted ERISA plans from an otherwise generally applicable garnishment provision, *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 828 n.2, 100 L. Ed. 2d 836, 108 S. Ct. 2182 (1988); and a common-law cause of action premised on the existence of an ERISA plan, *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 140, 112 L. Ed. 2d 474, 111 S. Ct. 478 (1990). Where a State's law acts immediately and exclusively upon ERISA plans, as in *Mackey*, or where the existence of ERISA plans is essential to the law's operation, as in *Greater Washington Bd. of*

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[6] The Western District of Kentucky in *Community Health Partners, Inc. v. Kentucky*, 14 F. Supp. 2d 991, 995-1001 (W.D. Ky. 1998), also found the AWP provisions "related to" ERISA plans, but only under the "connection with" prong of the "relation to" analysis. That court did not believe that the statute referred to ERISA plans in the manner that Supreme Court precedent requires for preemption under the "reference to" prong. Specifically, the court believed that under Dillingham, a law will only "refer to" an ERISA plan for preemption purposes if it "acts immediately and exclusively upon ERISA plans" or "where the existence of ERISA covered plans is essential to the law's operation." *Id.* at 995-96. We disagree with the district court's "reference to" analysis for the reasons set forth in this opinion.

> *Trade* and *Ingersoll-Rand*, that "reference" will result in preemption.

519 U.S. at 324-25, 117 S. Ct. at 837-38, 136 L. Ed. 2d at 799.

In *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 108 S. Ct. 2182, 100 L. Ed. 2d 836 (1988), the Court discussed Georgia Code Annotated § 18-4-22.1 (1982), which specifically exempted ERISA plans from Georgia's general garnishment law. The Court noted that even though Georgia's legislature may have enacted § 18-4-22.1 to help effectuate ERISA's underlying purpose, it would still be preempted if it fell within ERISA's preemption provision. Finding that § 18-4-22.1 was indeed preempted, the Court stated:

> [A]dhering to our precedents in this area, we hold Ga. Code Ann. § 18-4-22.1, which singles out ERISA employee welfare benefit plans for different treatment under state garnishment procedures, is preempted under § 514(a). The state statute's express reference to ERISA plans suffices to bring it within the federal law's preemptive reach.

Mackey, 486 U.S. at 830, 108 S. Ct. at 2186, 100 L. Ed. 2d at 844. In a footnote, the Court indicated that the "different treatment" was illustrated not just by the express reference to ERISA plans in the statute's language, but also in the disparate treatment accorded to non-ERISA pension and benefit plans under Georgia law. *See* 486 U.S. 825, 830 at n.4. The effect was that only ERISA welfare benefit plans were singled out for protection under the statute, an impermissible result.

The district court in the case at bar relied on *Mackey* in determining whether Kentucky's AWP statutes referred to an ERISA plan. The district court first observed that under Kentucky's statute, "health benefit plans" were defined to include, among other things, "a self-insured plan or plan provided by a multiple employer welfare arrangement, to the extent permit-

ted by ERISA." Based on this language, the court concluded that "it is clear that the AWP statutes 'refer to' ERISA employee benefit plans." In support, the court cited *De Buono v. NYSA-ILA Medical & Clinical Services Fund*, 520 U.S. 806, 815, 117 S. Ct. 1747, 1752, 138 L. Ed. 2d 21, 30 (1997), which cited *Mackey* for the principle that a provision that explicitly refers to ERISA in defining the scope of the state law's application is preempted.

The district court noted that the Western District of Kentucky in *Community Health Partners, Inc. v. Kentucky*, 14 F. Supp. 2d 991 (W.D. Ky. 1998), disagreed with its analysis of the same statute. The *Community Health Partners* court, relying on language in *Dillingham*, found that Kentucky's AWP statute did not "refer to" an ERISA plan because the law did not act "immediately and exclusively upon ERISA plans" and because the existence of ERISA plans was not essential to the law's operation. *Id.* at 995-96. However, the district court in the present case disagreed with the *Community Health Partners* court, finding that "Mackey makes it clear that when a statute 'singles out ERISA employee benefit plans for different treatment' the statute's 'express reference to ERISA plans suffices to bring it within the federal law's preemptive reach.'" J.A. at 12 n.6.

Other courts have reached similar conclusions. The Eighth Circuit in *Prudential Insurance Co. of America v. National Park Medical Center, Inc.*, 154 F.3d 812 (8th Cir. 1998), found that an Arkansas AWP statute containing language comparable to Kentucky's provisions was preempted due to its reference to employee benefit plans covered by ERISA. The court noted that the law expressly stated its provisions "shall not apply to self-funded or other health benefit plans that are exempt from state regulation by virtue of [ERISA]." *Id.* at 822. Accordingly, the court determined that § 23-99-209 of the Arkansas Patient Protection Act ("PPA") referred to ERISA plans, as it "undeniably makes an express reference to ERISA and attempts to exclude from coverage of the PPA

at least some ERISA plans. Thus it 'singles out ERISA employee benefit plans for different treatment under state [law], [and therefore] is preempted under § [1144(a)].'" *Id.* at 824 (quoting *Mackey*). *See also Cigna Health Plan of La., Inc. v. Louisiana*, 82 F.3d 642, 647-48 (5th Cir. 1996) (concluding that Louisiana's AWP statute, § 2202(5)(c) of the State's Health Care Cost Control Act, which applied to "group purchasers," referred to ERISA qualified plans by defining "group purchasers" to include entities such as "'Taft-Hartley trusts or employers who establish or participate in self-funded trusts or programs' which 'contract [with health care providers] for the benefit of their . . . employees.'").

Although in the recent case of *Washington Physicians Service Association v. Gregoire*, 147 F.3d 1039 (9th Cir. 1998), *cert. denied*, 525 U.S. 1141, 119 S. Ct. 1033, 143 L. Ed. 2d 42 (1999), the court found that Washington's "every category of provider" statute did not contain a "reference to" or "connection with" employee benefit plans, the statute at issue is distinguishable from Kentucky's AWP laws. The court noted that by the statute's definition, "health carrier" only included disability insurers, health care service contractors, or health maintenance organizations. *See id.* at 1043. Employer-sponsored, self-funded plans were excluded not by a provision of the act, but rather by limiting the act's application to only the mentioned entities. As a result, the act contained no reference whatsoever to ERISA-covered employee benefit plans.

While a mere reference to an ERISA plan, without more, may not be enough to cause preemption, Supreme Court precedent shows that if such a reference is combined with some effect on those plans, such as singling them out for different treatment, preemption will result. *See, e.g., Mackey*, 486 U.S. at 830 n.4, 108 S. Ct. at 2186, 100 L. Ed. 2d at 844; *cf. District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 113 S. Ct. 580, 121 L. Ed. 2d 513 (1992)

(finding that a state law that imposes requirements merely by reference to ERISA is preempted).

We conclude that Kentucky's AWP statutes "relate to" ERISA plans and are therefore preempted, unless they are found to be statutes that regulate "insurance" under the savings clause of § 514(b)(2)(A). This conclusion also involves consideration of the "deemer" clause, § 514(b) (2)(B), which ensures that ERISA employee benefit plans are not deemed to be engaged in the business of insurance in applying the savings clause. Under the deemer clause, state insurance laws that apply directly to ERISA *self-insured* plans do not fall within the savings clause and thus are preempted. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 105 S. Ct. 2380, 85 L. Ed. 2d 728 (1985); *FMC Corp. v. Holliday*, 498 U.S. 52, 111 S. Ct. 403, 112 L. Ed. 2d 356 (1990).

The Kentucky legislature, aware of its inability to regulate self-insured ERISA plans, sought to include such plans - as well as multiple employer welfare arrangements (MEWAs) - only "to the extent permitted by ERISA." The effect of this provision is to exclude self-insured ERISA plans from coverage of the statute by virtue of the deemer clause and to include MEWAs only to the extent state regulation is permitted under 29 U.S.C. § 1144(B)(6).[7] In *Community Health Partners v. Commonwealth of Kentucky*, 14 F. Supp. 2d 991 (W.D. Ky. 1998), District Judge McKinley pointed this out in his opinion:

> The fact that the Kentucky legislature chose to allow for regulation of MEWAs and self-insured plans "to the extent permitted by ERISA" suggests that the legislature was well aware of the preemptive force of ERISA.

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[7] 29 U.S.C. § 1144(B)(6) permits state laws that regulate insurance to apply to MEWAs under the circumstances set forth in that section.

> As noted by Defendant, the phrase appears merely to restate the "deemer clause" by exempting self-insured ERISA plans from the scope of the AWP statute. The "deemer clause" prevents a state law from "deeming" an employee benefit plan to be an insurance company for the purpose of any law purporting to regulate the business of insurance. 29 U.S.C. 1144(b)(2)(B). The deemer clause thus effectively prevents states from subjecting self-insured plans to state insurance regulation. On the other hand, insured plans - plans that purchase insurance - are subject to state laws regulating the insurance industry. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732, 105 S. Ct. 2380, 85 L. Ed. 2d 728 (1985).

14 F. Supp. 2d at 995 n.4.

As the Supreme Court noted in *UNUM Life Insurance Co. v. Ward*, 526 U.S. 358, 367 n.2, 119 S. Ct. 1380, 1386, 143 L. Ed. 2d 462, 472 (1999):

> Self-insured ERISA plans ... are generally sheltered from state insurance regulation.

The Kentucky Act provides that shelter by its exclusion of ERISA self-insured plans from its coverage, but its reference to ERISA plans and its exclusion of self-insured ERISA plans from its coverage clearly bring the statute within the "refer to" prong of the "relate to" analysis.

B. Connection With

While the fact that the Kentucky statutes "refer to" ERISA employee benefit plans is enough to potentially preempt them on that basis alone, their "connection with" such plans offers an alternative basis for such preemption. Analysis under the "connection with" prong has changed somewhat after the Supreme Court's opinion in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insur-*

ance Co., 514 U.S. 645, 115 S. Ct. 1671, 131 L. Ed. 2d 695 (1995).[8] The *Travelers* Court discussed whether ERISA's preemption provision altered the starting presumption that Congress does not intend to supplant state law. *See id.* at 654-55, 115 S. Ct. at 1676-77, 131 L. Ed. 2d at 704. While observing that this presumption remained unaltered, the Court recognized that its prior attempts to construe "relate to" did not provide much help drawing the line as to what should be preempted. *See id.* at 655, 115 S. Ct. at 1677, 131 L. Ed. 2d at 705. The Court concluded that in order to determine whether the normal presumption against preemption has been overcome in a particular case, it "must go beyond the unhelpful text and the frustrating difficulty of defining [§ 514 (a)'s] key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Id.* at 656, 115 S. Ct. at 1677, 131 L. Ed. 2d at 705. The Court found that the "basic thrust" of the clause was "to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans," and observed that under its past case law it had found ERISA to preempt state laws that mandated employee benefit structures or their administration. *Id.* at 657-58, 115 S. Ct. at 1677-78, 131 L. Ed. 2d at 706. The use of this approach for "connection with" analysis was subsequently endorsed and used by the Court both in *Dillingham*

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[8] In *De Buono v. NYSA-ILA Medical & Clinical Services Fund*, 520 U.S. 806, 117 S. Ct. 1747, 138 L. Ed. 2d 21 (1997), the Court explained its change in focus, stating that its earlier ERISA cases had not required a fine analysis of the scope of ERISA's "relate to" language, because the state laws at issue had a clear "connection with or reference to" ERISA benefit plans. *De Buono*, 520 U.S. at 813, 117 S. Ct. at 1751, 138 L. Ed. 2d at 28-29. The Court explained that in *Travelers*, however, it was forced to confront directly whether ERISA's "relates to" language altered the normal starting presumption that Congress does not intend to supplant state law. *See id.*

and *De Buono* and recognized by this circuit in *Davies v. Centennial Life Insurance Co.*, 128 F.3d 934 (6th Cir. 1997).[9]

Using the *Travelers* "connection with" analysis, the district court in the case at bar determined that Kentucky's AWP laws had a connection with ERISA plans. The court found that while the law did not operate directly on ERISA plans, it effectively required benefit plans to purchase benefits of a certain structure, thereby bearing indirectly but substantially on all insured plans. As a result, the court concluded that the AWP statutes did more than just indirectly affect the cost of ERISA plans; the AWP statutes mandated benefit structures.

Two other district courts in Kentucky recently drew the same conclusion while addressing the same statute. In *Community Health Partners, Inc. v. Kentucky*, 14 F. Supp. 2d 991, 1000-01 (W.D. Ky. 1998), the court found Kentucky's AWP provision, located then at § 304.17A-110(3), to be similar in effect to the mandated benefit law in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 105 S. Ct. 2380, 85 L. Ed. 2d 728 (1985). In *Metropolitan*, the Supreme Court held that the Massachusetts mandated benefit law "related to" ERISA plans because the statute bore indirectly, but substantially, on all insured employee benefit plans by effectively requiring the plans to purchase mental health benefits when purchasing a certain kind of common insurance policy. *See id.* at 739, 105 S. Ct. at 2388, 85 L. Ed. 2d at 740. Similarly, the *Community Health Partners* court believed that the AWP law effectively mandated the benefit structure of ERISA plans and regulated the relationship between traditional ERISA en-

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[9] In changing its "relate to" analysis in *Travelers*, the Court appears to have been addressing only the "connection with" prong, as its statements in later cases indicate the "reference to" prong was unaffected. *See De Buono*, 520 U.S. at 815 n.15, 117 S. Ct. at 1752, 138 L. Ed. 2d at 30; *Dillingham*, 519 U.S. at 324, 117 S. Ct. at 837, 136 L. Ed. 2d at 799.

tities, *i.e.*, the plan, the employer, and the plan fiduciaries and beneficiaries. 14 F. Supp. 2d at 997.

A recent memorandum opinion, *Ward v. Alternative Health Delivery Systems, Inc.*, 55 F. Supp. 2d 694 (W.D. Ky. 1999), held that § 304.17A-171, which contains regulations of a health benefit plan's use of chiropractic services, including an AWP provision, was preempted by ERISA due to its connection with employee benefit plans. *Id.* at 701. The judge found that:

> By specifically prohibiting health organizations from offering networks with limited chiropractic providers, the statute mandates the plan's structure. Moreover, the statute also dictates that all covered participants shall have access to the chiropractor of their choice. This too dictates a certain structure to which an employer's health care plan must succumb. As such this claim also falls within the realm of ERISA preemption.

Id. at 699.

Some academic literature has suggested that the Supreme Court's post-*Travelers* case law may represent a "sea change" in the "relation to" analysis; however, neither the Court's nor the circuits' opinions yet confirm this assertion.[10] The two appellate courts that have addressed the issue since *Travelers* both found that the AWP statutes at issue were "connected with" ERISA covered employee benefit plans. *See CIGNA Healthplan of La., Inc. v. Louisiana*, 82 F.3d 642, 648-49 (5th

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[10] While Justice Scalia has suggested that the Court should really be applying field preemption, rather than the express preemption test it has created for analyzing ERISA's preemption provisions, *Dillingham*, 519 U.S. at 335-36, 117 S. Ct. at 843, 136 L. Ed. 2d at 806 (1997) (Scalia, J., concurring), absent further direction from the whole Court on this issue we must continue to apply the traditional analysis.

Cir. 1996); *Texas Pharmacy Ass'n v. Prudential Ins. Co. of Am.* 105 F.3d 1035, 1037 (5th Cir. 1997). In both of these cases, the courts recognized that under the reasoning of *Travelers*, state laws that mandate employee benefit structures are preempted. Finding the AWP statutes at issue did exactly that, both courts concluded that they were trumped by ERISA's preemption provision. *Cf. Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500, 502 (4th Cir. 1993) (finding, in a case prior to *Travelers*, that Virginia's AWP statute related to ERISA covered employee benefit plans because it eliminated an insurer's ability to choose limited provider networks).

We are convinced that even after the change of emphasis worked by *Travelers* on the "connection with" prong of the Supreme Court's "relation to" preemption analysis, the district court in this case was correct in finding that former § 304.17A-110(3) (now § 304.17A-270) and present § 304.17A-171 were both "connected with" ERISA covered plans. They not only affect the benefits available by increasing the potential providers, they directly affect the administration of the plans.

The Kentucky statutes in question meet both prongs of the "relation to" analysis and thus are preempted, unless found to be statutes that regulate insurance under the savings clause of § 514(b) (2)(A).

III. Insurance Savings Clause

Having concluded that Kentucky's AWP laws relate to ERISA covered employee benefit plans, and are thus within the scope of ERISA's preemption provision, the Court must then determine whether the laws fall within ERISA's savings clause. The savings clause states that, "[e]xcept as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities." ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). This provision provides a broad and important exception to ERISA's

preemption provision, saving state laws that relate to ERISA plans from preemption so long as they "regulate insurance." Much like the preemption provision itself, however, the scope of the savings clause has proved difficult to determine from its sparse language.[11]

The Supreme Court has endeavored to provide guidance on what it means to "regulate insurance," first addressing the issue in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 105 S. Ct. 2380, 85 L. Ed. 2d 728 (1985), and most recently describing the test in *UNUM Life Insurance of America v. Ward*, 526 U.S. 358, 119 S. Ct. 1380, 143 L. Ed. 2d 462 (1999), stating:

> Our precedent provides a framework for resolving whether a state law "regulates insurance" within the meaning of the saving clause. First we ask whether, from a "common sense view of the matter," the contested prescription regulates insurance. Second, we consider three factors employed to determine whether the regulation fits within the "business of insurance" as that phrase is used in the McCarran-Ferguson Act:

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[11] *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739-40, 105 S. Ct. 2380, 2389, 85 L. Ed. 2d 728, 740 (1985), in which the Court stated:

> [T]he sphere in which § 514(a) operates was explicitly limited by § 514(b)(2). The insurance savings clause preserves any state law "which regulates insurance, banking, or securities." The two pre-emption sections, while clear enough on their faces, perhaps are not a model of legislative drafting, for while the general preemption clause broadly pre-empts state law, the saving clause appears broadly to preserve the States' lawmaking power over much of the same regulation. While Congress occasionally decides to return to the States what it has previously taken away, it does not normally do both at the same time.

> "first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry." (internal citations omitted).

Ward, 526 U.S. at 367-68, 119 S. Ct. at 1386, 143 L. Ed. 2d at 472.

The Court noted that the three McCarran-Ferguson factors are "'considerations [to be] weighed' in determining whether a state law regulates insurance" and that "none of these criteria is necessarily determinative in itself." *See id.* at 373, 119 S. Ct. at 1389, 143 L. Ed. 2d at 476. Therefore, in determining whether Kentucky's AWP laws are saved from preemption by ERISA § 514(b)(2)(A), one must first ask whether as a matter of common sense they regulate insurance, and then look to the McCarran-Ferguson factors as checking points or guideposts to aid the analysis.

In *Ward*, the Court was faced with the question of whether California's notice-prejudice rule[12] was preempted by ERISA. The parties had agreed that California's notice-prejudice rule "related to" ERISA covered plans under § 514(a), so the Court had only to determine whether the rule was saved by the insurance regulation savings clause of § 514(b)(2)(A). 526 U.S. at 367, 119 S. Ct. at 1386, 143 L. Ed. 2d at 472. The Court began with the common sense prong of its insurance regulation savings clause test, observing that:

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[12] The rule states, "a defense based on an insured's failure to give timely notice [of a claim] requires the insurer to prove that it suffered actual prejudice. Prejudice is not presumed from delayed notice alone. The insurer must show actual prejudice, not the mere possibility of prejudice." *Ward*, 526 U.S. at 366-67, 119 S. Ct. at 1386, 143 L. Ed. 2d at 472.

> The California notice-prejudice rule controls the terms of the insurance relationship by "requiring the insurer to prove prejudice before enforcing proof-of-claim requirements." *Cisneros*, 134 F.3d 939, 945. As the Ninth Circuit observed, the rule, by its very terms, "is directed specifically at the insurance industry and is applicable only to insurance contracts." *Ibid.*; see Brief for United States as Amicus Curiae 12 ("[O]ur survey of California law reveals no cases where the state courts apply the notice-prejudice rule as such outside the insurance area. Nor is this surprising, given that the rule is stated in terms of prejudice to an 'insurer' resulting from untimeliness of notice."). The rule thus appears to satisfy the common-sense view as a regulation that homes in on the insurance industry and does "not just have an impact on [that] industry." *Pilot Life*, 481 U.S. 41, 50, 107 S. Ct. 1549, 95 L. Ed. 2d 39.

Ward, 526 U.S. at 368, 119 S. Ct. at 1386-87, 143 L. Ed. 2d at 472-73.

Ward makes it clear that the most important aspect of the test is whether from a common sense view of the matter the contested statute regulates insurance. The three McCarran-Ferguson factors are of secondary importance, serving only as "checking points" or "guideposts" and not as essential elements. Indeed, in *Ward*, the Court ignored the first McCarran-Ferguson factor altogether in its analysis of the challenged statute in that case.

The Kentucky Act meets the common sense test in that it clearly does regulate insurance. The fact that it includes within its reach HMOs as well as traditional insurance companies does not take it out of the realm of insurance regulation. We agree with the reasoning of the Ninth Circuit in *Washington Physicians Service Association v. Gregoire*, 147 F.3d 1039 (9th Cir. 1998), in which the Court said:

> The Washington law is "specifically directed" toward the insurance industry, *Pilot Life*, 481 U.S. at 50, 107 S. Ct. 1549, because it operates directly on HMOs and HCSCs, entities that are engaged in the business of health insurance. "The primary elements of an insurance contract are the spreading and underwriting of a policyholder's risk." *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 211, 99 S. Ct. 1067, 59 L. Ed. 2d 261 (1979), citing 1 G. Couch, Cyclopedia of Insurance Law § 1:3 (2d ed.1959)("It is characteristic of insurance that a number of risks are accepted, some of which involve losses, and that such losses are spread over all the risks so as to enable the insurer to accept each risk at a slight fraction of the possible liability upon it."). The only distinction between an HMO (or HCSC) and a traditional insurer is that the HMO provides medical services directly, while a traditional insurer does so indirectly by paying for the service, *Anderson v. Humana, Inc.*, 24 F.3d 889, 890 (7th Cir. 1994), but this is a distinction without a difference. *Metropolitan Life*, 471 U.S. at 741, 105 S. Ct. 2380 (explaining that nothing in ERISA "purports to distinguish between traditional and innovative insurance laws"); *Klamath-Lake Pharmaceutical Ass'n v. Klamath Med. Serv. Bureau*, 701 F.2d 1276, 1286-87 (9th Cir. 1983). In the end, HMOs function the same way as a traditional health insurer: The policyholder pays a fee for a promise of medical services in the event that he should need them. It follows that HMOs (and HCSCs) are in the business of insurance.

147 F.3d at 1045-46.[13] In *Anderson v. Humana, Inc.*, 24 F.3d 889, 892 (7th Cir. 1994), the court said: "Because HMOs

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[13] As noted earlier, the Ninth Circuit in *Gregoire* found that the Washington statute did not come within the scope of ERISA's pre-emption clause. Nevertheless, the Court found that, even if it

spread risk - both across patients and over time for any given person - they are insurance vehicles under Illinois law." They are likewise "insurance vehicles" under Kentucky law.

It is true that the statutes would reach certain self-insured health care benefit plans that are not under ERISA's protective "deemer" clause, *e.g.*, self-insured government plans and self-insured church plans, because they are excluded entirely from ERISA's coverage under 29 U.S.C. § 1003(b). We do not see this fact, however, as any barrier to a finding that a common sense view is that the statutes regulate insurance. We know of no reason why it is not within the authority of a state in enacting laws dealing with insurance to include within such laws entities that act as self-insurers as well as entities who purchase insurance. As the author of a well-known treatise has said, "Self-insurance has often led courts and legislatures to struggle with the intriguing question of whether a party who has not purchased insurance, effectively acting as its own insurer, should be the equivalent of an insurer." 1 COUCH ON INSURANCE 3d § 10.2. It is pointed out that this difficulty in modern practice is frequently removed by express statutory provisions specifying that a particular requirement does or does not apply to self-insured entities. *Id.* Kentucky has done this by expressly including self-insurers -- to the extent permitted by ERISA -- within the coverage of the statutes in question.

The state's regulation of health benefit plans is set forth in Kentucky's Insurance Code (Chapter 304 of Title XXV dealing with Business and Financial Institutions). Subtitle 17A of the Insurance Code deals with health insurers and health benefit plans. Section 304.17A-005 contains the definition of words used in that subtitle. Paragraph 22 provides:

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did, the statute dealt with the regulation of insurance and would therefore be saved from pre-emption.

> "Insurer" means any insurance company; health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association, or nonprofit hospital, medical-surgical, dental, or health service corporation authorized to transact health insurance business in Kentucky.

"Health benefit plan" is also defined, the relevant portion of that definition tracking the above definition of "insurer:"

> "Health benefit plan" means any hospital or medical expense policy or certificate; nonprofit hospital, medical-surgical, and health service corporation contract or certificate; provider sponsored integrated health delivery network; a self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA; health maintenance organization contract; . . .

Ky. Rev. Stat. Ann. § 304.17A-005(17).

The AWP provision of Kentucky's Insurance Code specifically is directed at "insurers" by providing that:

> A *health insurer* shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer, including the Kentucky State Medicaid program and Medicaid partnerships (emphasis added).

Ky. Rev. Stat. Ann. § 304.17A-270.

The chiropractic AWP provision specifically adopts the definition of a health benefit plan as set forth in Kentucky Revised Statutes Annotated § 304.17A-005 and defines "health care insurer" as any entity "authorized by the state of Kentucky to offer or provide health benefit plans, policies,

subscriber contracts, or any other contracts of similar nature which indemnify or compensate health care providers for the provision of health care services." Ky. Rev. Stat. Ann. § 304.17A-170(7).

The Kentucky AWP laws are thus specifically directed toward "insurers" and the insurance industry and are ones that from a "common sense view" regulate insurance.

The fact that the deemer clause prevents ERISA self-insured plans from being considered as engaging in the business of insurance does not mean that self-insured plans, by their nature, do not involve the business of insurance and are beyond the reach of state regulations dealing with insurance. The distinction between plans funded by the purchase of insurance and plans that are funded by employers as self-insured plans results from "a distinction created by Congress in the 'deemer clause,' a distinction Congress is aware of and one it has chosen not to alter." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. at 747, 105 S. Ct. at 2393, 85 L. Ed. 2d at 745. It is not a distinction based upon a concept that employers who choose to be self-insurers cannot be considered insurers subject to state regulations dealing with insurance. Therefore, the fact that the Kentucky statute reaches self-insurers who are not protected by ERISA's deemer clause does not detract from its characterization as a statute regulating entities engaged in the business of health insurance.

As noted earlier, the Kentucky statutes exclude from their scope self-insured ERISA plans. If such a plan provides for a limited group of providers, the AWP laws would not compel a change in that plan, regardless of the nature of the entity administering the plan. It could not be enforced, in our opinion, against the employer who has a self-insured ERISA plan nor against the administrator of such a plan, even if the administrator is an entity, such as an HMO, which would be subject to the statute if it were acting not as a mere administrator but as an insurer of its own plan. In *Light v. Blue Cross and Blue Shield*, 790 F.2d 1247 (5th Cir.1986), the court re-

jected the argument that a state law could be enforced against the administrator of a self-insured ERISA plan because the deemer clause, § 514(b)(2)(B), which protects such plans from state regulation, does not expressly include plan administrators among the exempted entities. The court found the fact that administrators of self-insured plans are not mentioned in the deemer clause to be of no significance, and because the state law was preempted, the claim against the administrator of the plan based on that law could not be brought, even though the plan itself provided that the contracts between the employer and the plan administrator would "conform to applicable state laws." The court observed that, "If ERISA preempts state law, there is no applicable state law to which the administrator must conform." *Id.* at 1248.

In *Prudential Insurance Company of America v. National Park Medical Center, Inc.*, 154 F.3d 812 (8th Cir. 1998), the court found that an Arkansas statute that contained an AWP provision did not meet the common sense test because, in part, its scope included "employers and administrators of self-insured plans" (although the statute excluded ERISA self-funded plans). As noted above, however, we do not believe that inclusion of self-insurers not protected by the deemer clause, as well as purchasers of insurance, within the statute's reach in itself removes the statute from being viewed a permissible regulation of insurance based upon "a common understanding of insurance regulation." Also, unlike the Arkansas statute, the Kentucky statutes do not include "administrators of self-insured plans." They are directed towards and limited to health care "insurers."[14]

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[14] The dissent contends that Kentucky's AWP provisions apply to third parties that a self-insured ERISA plan hires to administer its plan benefits. This contention, however, is based upon the dissent's reading of the repealed Kentucky statutes which prohibited "health care benefit plans" from discrimination and defined health benefit plans as including a health service corporation contract and a health maintenance organization contract. The present Kentucky

Texas Pharmacy Association v. Prudential Insurance Company of America, 105 F.3d 1035 (5th Cir. 1997), contains the statement that if a self-insured employer, not subject to the any willing provider statute, "signed up with an HMO or PPO, those organizations would be subject to the statute, even if there is no insurance company involved." *Id.* at 1039. The

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statutes eliminate any ambiguity as to whether administrators under contracts with benefit plans are included within the scope of the statutes. They obviously are not. The current Kentucky statute prohibits *only* "a health *insurer*" from discrimination. Ky. Rev. Stat. Ann. § 304.17A-270. As the defendant correctly notes, "the new statute refers to health insurers which shall not discriminate among providers rather than health care benefit plans which strengthens Appellee's arguments that the AWP law regulates insurance." Brief of Defendant-Appellee, p. 3 n.5. An entity that merely administers a plan for a health insurer and does not participate in the underwriting of the risk is not an "insurer" and is not within the scope of Kentucky's current statutes which are, by their express terms, directed solely at health insurers. This is acknowledged by the defendant:

> The statutes establish that health insurers, which assume financial risk, cannot discriminate against qualified providers. Therefore, although the statute tenuously affects the relationship between insurers and providers, its focus is on the contractual relationship between the insurer and the insured.
>
> Brief of Defendant-Appellee, p. 18.

Thus, under the current AWP statute, the insurer of a plan, including a self-insurer of a non-ERISA benefit plan, must not discriminate against qualified providers, and any health benefit plan of such insurer must conform to the statute. While not included as an entity subject to the statute, a plan administrator would necessarily be required to comply with the plan's non-discriminatory requirement. With respect to self-insured ERISA benefit plans, the insurer of such plans is beyond the scope of the statute by its express terms, and the administrators of such plans who act solely as administrators and not as insurers are likewise beyond the scope of the statute because of its application only to health insurers.

court was presumably referring to the HMO or PPO acting as the administrator of the employer's self-funded plan. We believe, however, that, as the court in *Light* observed, if ERISA preempts the state law with respect to self-funded plans, there is no state law to which the administrator of the self-funded plan must conform. Furthermore, as previously noted, the Kentucky statute is directed toward and applies to only insurers and not to plan administrators. *Supra*, note 14. A plan administrator that does nothing more than administer the plan of a self-insured employer is not engaged in "the underwriting and spreading of risk," *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 221, 99 S. Ct. 1067, 1077, 59 L. Ed. 2d 261, 274 (1979), and in our view, would not be considered an "insurer" of a health benefit plan as that term is used in Kentucky's AWP laws.[15]

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[15] The dissent believes that the majority is "apparently saying that the law is clearly preempted and not saved insofar as it applies to plan administrators, and then arguing that due to this preemption, the statute does not apply to entities outside the insurance industry." According to the dissent, this is an "attempt to dissect Kentucky's AWP provisions, dismissing some of the provision's applications as preempted and then applying saving clause analysis only to those applications it wishes to retain." This is a misreading of the majority opinion. The majority does not say that the Kentucky statutes are preempted insofar as plan administrators are concerned. The majority is saying that insofar as self-insured ERISA plans are concerned, the Kentucky AWP laws could not be enforced against a plan administrator, as a matter of law, under the reasoning of *Light*, because if the law is preempted with respect to self-insured plans, "there is no applicable state law to which the administrator must conform." More importantly, however, is the fact that the present Kentucky AWP statute, Ky. Rev. Stat. Ann. § 304.17A-270, prohibits only health insurers from discrimination and would have no application to an entity acting merely as an administrator of an insurer's plan. Although the chiropractic statute still refers to a prohibition against "health benefit plans" discrimination, Ky. Rev. Stat. Ann. § 304.17A-171(2), the majority believes that, prop-

In *Metropolitan Life*, 471 U.S. at 743-44, 105 S. Ct. at 2391, 85 L. Ed. 2d at 743, the Supreme Court said:

> Congress was concerned [in the McCarran-Ferguson Act] with the type of state regulation that centers around the contract of insurance.... The relationship between insurer and insured, the type of policy which could be issued, its reliability, its interpretation, and enforcement - these were the core of the "business of insurance." [T]he focus [of the statutory term] was on the relationship between the insurance company and the policyholder. Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the "business of insurance." *SEC v. National Securities, Inc.*, 393 U.S. 453, 460, 89 S. Ct. 564, 568, 21 L. Ed. 2d 668 (1969).

The Kentucky AWP laws deal directly with the relationship between insurers and insureds under health benefit plans. They affect restrictions by the insurers on the number of health care providers available to the insureds under such plans; they increase benefits to the insureds by giving them greater freedom to choose health care providers under the plans; and they are aimed at regulating this insurance relationship. They are part of a comprehensive subtitle of Kentucky's insurance code regulating health benefit plans, and they are, in our view, clearly laws which, in a common sense view of the matter, "regulate insurance" and thus are saved from preemption.

Consideration of the three McCarran-Ferguson factors used in the second step of the analysis as "checking points" or "guideposts" does not require a different result. First, although certainly a debatable issue, we agree with the reason-

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erly construed, this encompasses insurers of health benefit plans and not mere administrators of such plans.

ing of the Fourth Circuit in *Stuart Circle Hospital Corp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir. 1993), that the first factor – "transferring or spreading the policyholder's risk" - is satisfied:

> There are several components to the "policyholder's risk." They include the types of illness and injury that the insurance contract covers, provision for treatment, and the cost of treatment. The Virginia statute affects the type and cost of treatment available to an insured. If a PPO unreasonably restricts the providers of treatment, even though they meet the insurer's standards, it denies an insured the choice of doctor or hospital that may best suit the insured's needs, unless the insured is willing and able to pay all or part of the cost of the doctor or hospital that is not preferred by the insurer. This is a restriction of the insured's benefits. By its prohibition against unreasonable restriction of providers, the Virginia statute spreads the cost component of the policyholder's risk among all the insureds, instead of requiring the policyholder to shoulder all or part of this cost when seeking care or treatment from an excluded doctor or hospital of his or her choice.

Id. at 503.

Plaintiffs point out that the Kentucky statutes in question do not require health benefit plans to contract with any additional provider, but only with providers who are willing to meet the network's terms and conditions. While this is unquestionably true, it does not, in our view, change the fact that the statutes open an otherwise closed door, insofar as the availability of health care providers is concerned. Some may choose to go through that door and join the group of providers while others may not, but this does not mean that removal of a restriction on availability of providers is not a benefit conferred on the insureds. It effectively changes the terms of the

policy, admittedly not in terms of covered medical conditions, but in terms of covered treatment by health care providers.[16]

While Plaintiffs understandably rely on *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 99 S. Ct. 1067, 59 L. Ed. 2d 261 (1979), in support of their position that the first factor is not present in this case, we believe *Royal Drug* does not require that conclusion. Unlike the health plans that are the subject of the Kentucky statutes, the insurer in *Royal Drug* did not restrict the number of providers in question. Blue Cross had offered to enter into a provider agreement with every licensed pharmacy in Texas. The benefit conferred on the insureds by the Kentucky AWP statutes - removal of restrictions on the number of providers - was already present in *Royal Drug*. The Supreme Court expressly noted, with reference to its discussion of contracts between the insurer and providers, "[t]his is not to say that the contracts offered by Blue Shield to its policyholders, as distinguished from its provider agreements with participating pharmacies, may not be the 'business of insurance' within the meaning of the [McCarran-Ferguson] Act." *Id.* at 230 n.37, 99 S. Ct. at 1082, 59 L. Ed. 2d at 279. Unlike *Royal Drug*, policyholders in Kentucky will benefit under their policies by

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[16] The dissent characterizes this conclusion as "mysterious." There is no mystery, however, in the undeniable fact that there is a difference between a closed network of providers chosen by the insurer and an open network of providers consisting of all providers - including providers preferred by the insured patients - who are willing to agree to the same terms as the other network providers. It is an extremely significant difference and one which not only changes the conditions of the plan but, by opening an otherwise closed door, expands the potential for inclusion of additional equally competent medical providers. It is in this sense that the AWP laws change "the terms of covered treatment by health care providers."

a new change in coverage, insofar as availability of providers is concerned.[17]

The policyholders in *Royal Drug* were "basically unconcerned with arrangements made between Blue Shield and participating pharmacies." *Id.* at 214, 99 S. Ct. at 1074, 59 L. Ed. 2d at 270. They paid a fixed price ($2.00) to a participating pharmacy for each prescription, and consequently they were not concerned with Blue Shield's cost for those prescriptions. Similarly, the policyholders in Kentucky are basically unconcerned with arrangements made between the insurers and participating providers regarding the insurers' cost for the medical services obtained by the insurers. The Kentucky statutes do not seek to change the terms and conditions of those cost arrangements. They merely require that any provider who is willing to meet the same terms and conditions of those arrangements should be allowed to join the list of participating providers. While Kentucky policyholders may be basically unconcerned with the insurers' compensation arrangements with participating providers, it cannot be said that they are unconcerned with a limitation on the number of such providers and the resulting restriction on their freedom of choice in seeking medical treatment.[18]

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[17] In *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F. Supp. 60 (D. Mass. 1997), the court, in considering a Massachusetts AWP statute, distinguished *Royal Drug* on the ground that, "[B]y directing insurers to open their networks, the Act should affect the availability of benefits to insureds by increasing their ability to select pharmacies of their choice. This does concern the relationship between insurer and policyholder, and thus may be considered part of the business of insurance." *Id.* at 71-72.

[18] The dissent states that, "It is true that the AWP laws would likely force insurers to pay higher rates." The economic effect of the AWP laws in question, however, is speculative at best. As one commentator has noted, "While AWP legislation could remove some of the incentive for health care providers to substantially discount their fees, provider reaction will most likely differ according

The Fifth Circuit has also distinguished *Royal Drug* in its discussion of a prior Texas AWP statute pertaining to pharmacies in *Texas Pharmacy Association v. Prudential Insurance Co. of America*, 105 F.3d 1035 (5th Cir. 1997), agreeing with the reasoning of the Fourth Circuit in *Stuart Circle Hospital Corp.* "Unlike the third-party pharmacy agreements in *Royal Drug*, the prior Texas statute directly regulated the terms of the insurance policy between the insurer and the insured." *Id.* at 1041.

Finally, it should be emphasized, in applying the McCarran-Ferguson factors, that "the focus of McCarran-Ferguson is upon the relationship between the insurance company and its policyholders," and state statutes aimed at regulating that relationship, "directly or indirectly, are laws regulating the 'business of insurance.'" *United States Dep't of the Treasury v. Fabe*, 508 U.S. 491, 501, 113 S. Ct. 2202, 2208, 124 L. Ed. 2d 449, 459 (1993). In *Fabe*, the Court held that, "[t]here can be no doubt that the actual performance of an insurance contract falls within the 'business of insurance,' as we understood that phrase in *Pireno* and *Royal Drug*." *Id.* at 503, 113 S. Ct. at 2209, 124 L. Ed. 2d at 461. Furthermore, in *Fabe*, the Court distinguished *Royal Drug* on the ground that it was an

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to the number of MCOs (managed care organizations) and providers present in each market." James W. Childs, Jr., *You May Be Willing, But Are You Able?: A Critical Analysis of "Any Willing Provider" Legislation*, 27 Cumb. L. Rev. 199, 210 (1996-1997). The same author reports that, insofar as any increase in consumer cost is concerned, there is some evidence that health care costs have not risen in those states that have enacted AWP legislation. *Id.* at 212. The possible economic effect on insurers must be weighed against "... the fact that managed care threatens Americans' right to freely choose their provider, and AWP legislation protects that right." *Id.* at 217-218. In any event, the decision of the Kentucky legislature to enact AWP laws is one left to the wisdom of that deliberative body, and the possible economic ramifications of its AWP laws should not concern this court.

antitrust law case, and the Court in that case was construing the words, "the business of insurance" contained in the second clause of § 2(b) of the McCarran-Ferguson Act, the antitrust law exemption (see 15 U.S.C. § 1012(b)).[19] The first clause, which commits laws "enacted by any State for the purpose of regulating the business of insurance" to the States is, according to the Supreme Court, "not so narrowly circumscribed." *Id.* at 504, 113 S. Ct. at 2209, 124 L. Ed. 2d at 461.

The second McCarran-Ferguson factor is, in our view, unquestionably present in this case. The ability of an insured to select a physician of his or her choice to treat a medical condition covered by the insurance is an integral part of the policy relationship between the insurer and the insured. In *Ward*, the Supreme Court dealt with a state law which required an insurer to show that it was prejudiced by an untimely proof of claim before it could avoid liability. The Court, as noted earlier, did not even pursue the issue of whether the statute satisfied the first factor - the risk alteration factor - because the other two factors verified the common sense view of the statute as one regulating insurance. The Court specifically rejected the argument that the statute was not such a law because it did not change any substantive terms of the insurance coverage.

> We reject UNUM's suggestion that because the notice-prejudice rule regulates only the administration of insurance policies, not their substantive terms, it cannot be an integral part of the policy relationship. *See Metropolitan Life*, 471 U.S. at 728 n.2, 105 S. Ct. 2380 (including laws regulating claims practices and requiring grace periods in catalogue of state laws that regulate insurance).

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[19] The Court in *Royal Drug* said, "It is well settled that exemptions from the antitrust laws are to be narrowly construed." 440 U.S. at 231, 99 S. Ct. at 1083, 59 L. Ed. 2d at 280.

526 U.S. at 375 n.5, 119 S. Ct. at 1390, 143 L. Ed. 2d at 477.

In Plaintiffs' view, the second factor is not satisfied because the AWP provisions leave the contract terms between the insurer and the insured unaltered, the medical risks remain the same, and even if an insured's provider decides to join the insured's network, the medical coverage remains the same. While it is admittedly true that the AWP laws do not change the substantive terms of the insurance coverage, it is not necessary that the statutes do this before they can be found to be statutes regulating insurance. *Id.* Kentucky's AWP laws do, however, directly impact the insurer-insured relationship because they affect restrictions on the network of providers available for treatment under the plan and they directly affect the administration of the plan. As in *Ward*, the statutes effectively create a mandatory contract term dealing with the manner in which the plan is administered by expanding covered treatment from a closed pool of providers to an open pool of providers. As the Fourth Circuit said in *Stuart Circle Hospital Corp.*, 995 F.2d at 503, "We repeat, treatment and cost are important components of health insurance. Regulations governing these components, such as the Virginia statute, are integral parts of the relationship between insurer and insured." In our view, the second McCarran-Ferguson factor is clearly satisfied.

We also conclude that the third factor - the statute's limitations to entities within the insurance industry - is satisfied. For reasons stated earlier, we believe that entities such as HMOs and self-insurers are engaged in the business of insurance along with the more widely recognized and more traditional commercial insurance companies, and that entities acting solely as plan administrators and not as "health insurers" are not within the scope of the statute. As District Judge McKinley pointed out in *Community Health Partners*:

> Whatever difference in form or structure that exists as between traditional insurance companies and HMOs, MEWAs, and provider-sponsored integrated health de-

livery networks is insufficient to establish that Kentucky's AWP law is not limited to entities within the insurance industry. To hold otherwise would require the Court to recognize form over substance and to refuse to recognize the natural evolution of the health insurance industry. *Cf. SEC v. Variable Annuity Life Ins. Co.*, 359 U.S. 65, 71, 79 S. Ct. 618, 3 L. Ed. 2d 640 (1959) (We realize that life insurance is an evolving institution. Common knowledge tells us that the forms have greatly changed even in a generation. And we would not undertake to freeze the concepts of "insurance". . . into the mold they fitted when these Federal Acts were passed.)

14 F. Supp. 2d at 1003-04.[20]

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[20] In *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F. Supp. 60 (D. Mass. 1997), a Massachusetts AWP statute, unlike the Kentucky AWP laws, did not exclude ERISA self-insured plans from its coverage. Because such plans are not insurers under the "deemer" clause, the argument was made that the state statute was not directed specifically toward the insurance industry. In rejecting this argument, the court noted that, with reference to ERISA self-insured plans, "any decision holding that the Act is saved from preemption by the insurance saving clause would have to recognize that the Act could not apply to the provision of services to self-insured plans. Because the Act would not apply to these uninsured relationships, it is unnecessary to consider whether the Act would lose its status as an insurance regulation because it purports to cover these relationships." *Id.* at 71 n.9. The court also pointed out that in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 105 S. Ct. 2380, 85 L. Ed. 2d 728 (1985), the fact that the state statute "applied by its terms to self-insured plans did not prevent the Supreme Court from concluding that the statute was limited to the insurance industry. Instead, the deemer clause simply prevented application of the statute to self-insured plans." *Id.* (internal citations omitted).

It must be reiterated and emphasized that the three McCarran-Ferguson factors are not required to be satisfied before a state law can be found to be a law regulating insurance. They are, as the Supreme Court pointed out in *Ward*, nothing more than "checking points" or "guideposts." The basic test is whether, from a common sense view, the Kentucky AWP laws in question regulate insurance. We conclude, as did the two Kentucky District Judges who carefully considered this question, that they do.

IV. Conclusion

With respect to Kentucky's AWP statute, Kentucky Revised Statutes Annotated § 304.17A-270 (Banks-Baldwin 1999), and Kentucky's chiropractic AWP statute, Kentucky Revised Statutes Annotated § 304.17A-171(2) (Banks-Baldwin 1999), the judgment of the district court is affirmed. Because the district court opinion does not discuss the additional requirements imposed by provisions (1) and (3)-(8) of § 304.17A-171, dealing with chiropractors and health benefit plans, this case is remanded to the district court for consideration in the first instance of the issue of their preemption by ERISA. [21]

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[21] Having concluded that Kentucky's AWP statutes are valid, there is no reason for the majority opinion to discuss any question of severability. The dissent, however, in discussing the question of severability, states that the majority "fails to mention, let alone discuss, how it severs Kentucky's AWP provision in such a manner that it no longer applies to third party plan administrators performing administrative functions for self-insured plans, thereby allowing it to conclude that the provision is saved in all other applications." As noted earlier, *supra*, note 15, this is a misreading of the majority opinion. The majority does not hold that the AWP statutes are preempted as applied to administrators of ERISA self-insured plans. It holds, instead, that because the statutes exclude ERISA self-insured plans, they could not be applied against an administrator of such plans under the reasoning of *Light* and, more importantly, they prohibit only health *insurers* from discrimination and, therefore, ex-

DISSENT

KENNEDY, Circuit Judge, dissenting. I write separately with respect to Part III of the majority's opinion to dissent from the majority's conclusion that Ky. Rev. Stat. Ann. §§ 304.17A-270[1] and 304.17A-171(2) (Banks-Baldwin 1995) fall within ERISA's insurance savings clause. I believe that Kentucky's any willing provider laws have little to do with insurance and are not saved from preemption by ERISA's Insurance Savings Clause as they do not regulate insurance as a matter of common sense and fail all three of the McCarran-Ferguson factors.

I. Insurance Savings Clause

A.

The district court in the case at bar devoted only a sentence to the common sense test, merely concluding that, "the common-sense view is that the AWP statutes regulate the business of insurance."[2] Instead the court spent most of its time analyzing the McCarran-Ferguson factors, which signifi-

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clude entities that act solely as administrators of the insurer's health benefit plan.

[1] As noted in the majority's opinion, § 304.17A-110(3) was the provision that was actually before the district court. However, both the parties have agreed that this appeal will govern § 304.17A-270 as well, as it is essentially a recodification of § 304.17A-110(3). Accordingly, unless otherwise noted I would apply my analysis of § 304.17A-110(3) to § 304.17A-270 as well.

[2] The district court in the companion case of *Community Health Partners, Inc. v. Commonwealth of Kentucky*, 14 F. Supp. 2d 991 (1998) devoted more room to its discussion of the common sense test. The court concluded that the statute satisfied the common sense test because it affected specific terms of the insurance policy, was located in the insurance code and regulated insurers or insurer related entities. *Id.* at 1001-02. While the district court conducted a careful analysis, I reach a contrary conclusion on all points for the reasons explained below.

cantly overlap the common sense test, being designed largely to guide a court's common sense determination. *See Unum Life Ins. of Am. v. Ward*, 526 U.S. 358, 119 S. Ct. 1380, 1389 143 L. Ed. 2d 462 (1999).

As the Supreme Court has generally started its savings clause analysis with the common sense test, I begin there as well. *See* 119 S. Ct. at 1386; *See also* Davies 128 F.3d 934 at 940 at 940-941 (6th Cir. 1997). In doing so, I conclude that the Kentucky AWP laws do not meet the common sense test because they are directed at the contracts between benefit plans and third parties, rather than being specifically directed at the insurance industry. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50, 107 S. Ct. 1549, 95 L. Ed. 2d 39 (1987) (concluding that to fall within the savings clause a law must be *specifically* directed at the insurance industry, which in part requires that the law define the terms of the relationship between the insurer and the insured, rather than the insurer and a third party). The laws do not change the relationship between the insurer and insureds, as the same medical conditions are covered after the AWP laws as were insured before the passage of these provisions. The underwriting of risk, the traditional earmark of insurance, *see Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 211-12, 99 S. Ct. 1067, 1073-74, 59 L. Ed. 2d 261 (1979), is in no way affected. Insureds are not free to attend the provider of their choice, as the AWP laws merely require employee benefit plans to accept previously excluded doctors that are qualified, willing to join the plan, and agree to abide by its terms.

Contrary to the majority's assertions, I believe it is also apparent that Kentucky's AWP laws clearly target more than just members of the insurance industry.[3] By their terms,

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[3] In addition to traditional insurance companies, Kentucky's AWP laws apply to entities such as HMO's and Health Service Corporations. These entities *might* be argued to fall within the insurance industry *if* they have agreed to accept the risk that the cov-

Kentucky's AWP laws apply to non-ERISA covered self-insured plans by defining health benefit plans to include "a self-insured plan . . . to the extent permitted by ERISA." §§ 304.17A-100(4)(a) and 304.17A-170(1). This definition includes self-insured plans not regulated by ERISA, such as government plans and church plans, which ERISA excludes from its coverage. See 29 U.S.C. § 1003 (b). The result is that these self-insured plans, which, as a matter of common sense ought to be considered as operating outside the insurance industry, are subject to Kentucky's AWP laws. *C.f. Cigna Health Plan of La., Inc. v. Louisiana*, 82 F.3d 642, 649 (5th Cir. 1996) (concluding that the statute was not saved as an insurance regulation because it was not limited to entities in the insurance industry as it applied to entities such as self-funded organizations, Taft-Hartley Trusts, or employers who establish and participate in self-funded trusts or programs as well as various intermediaries); *Blue Cross & Blue Shield of Alabama v. Neilsen*, 917 F. Supp. 1532, 1538-39 (N.D. Ala. 1996) (holding that Alabama's AWP statutes did not regulate insurance as a matter of common sense because they applied

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ered individual will need medical services in exchange for a fee. *See Group Life & Health Ins. v. Royal Drug*, 440 U.S. 205, 211, 99 S. Ct. 1067, 1073, 59 L. Ed. 2d 261 (1979) (stating that, "[t]he primary elements of an insurance contract are the spreading and underwriting of policyholder risk"). As such, they may be seen as underwriting policyholder risk and then covering that risk with the provision of medical services, rather than by paying for those services as a traditional insurer would. Given the somewhat subtle distinction in this difference, it could be argued that some HMO's and HSC's are engaged in the business of insurance. *See Washington Physicians Serv. Ass'n v. Gregoire*, 147 F.3d at 1045 (adopting this view); *but see Texas Pharmacy Ass'n*, 105 F.3d at 1038-39 (concluding that the Texas statute was not limited to entities within the insurance industry, as it applied to entities such as HMO's and PPO's). However, as Kentucky's AWP laws also apply to entities that are clearly outside the business of insurance, I believe that it is unnecessary for us to decide this issue.

to all employee benefit plans, including self-funded plans, and were thus not specifically directed toward the insurance industry) (vacated in part on appeal by *Blue Cross & Blue Shield of Alabama v. Nielsen*, 142 F.3d 1375 (11th Cir. 1998) due to mootness after the Alabama Supreme Court determined in a certified question that the law at issue did not apply to plaintiff); *Stuart Circle*, 995 F.2d at 503-04 (concluding that the AWP statute at issue, which *only* applied to insurance companies actively issuing insurance policies, met the common sense test as a law regulating insurance).

Significantly, the AWP provisions also apply to third parties that a self-insured ERISA plan hires to administer its plan benefits. As used in §§ 304.17A-110(3) and 304.17A-171, "health benefit plan" also includes Hospital, Health Service Corporation, and HMO contracts.[4] Section 304.17A-270 uses the term "Health Insurer" instead of "Health Benefit Plan," but similarly defines it to include any Insurance Company, HMO, or HSC.[5] Thus, Kentucky's AWP laws, by there very

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[4] Section 304.17A-100(4)(a) defined "Health Benefit Plan" as including:

> [A]ny hospital or medical expense policy or certificate; nonprofit hospital, medical-surgical, and health service corporation contract or certificate; a health benefit plan offered by a provider-sponsored integrated health delivery network; a self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA; health maintenance organization contract; and standard and supplemental health benefit plan as established by KRS 304.17A-160.

Ky. Rev. Stat. Ann. § 304.17A-100(4)(a). Section 304.17A-170 supplies a nearly identical definition of "Health Benefit Plan" (by reference to § 304.17A-005) for § 304.17A-171.

[5] As observed in part I of the majority opinion, § 304.17A-270 recodified § 304.17A-110(3), merely substituting "Health Insurer" for "Health Benefit Plan," and leaving the AWP provision other-

terms, prohibit *all* HMO's, HSC's and Insurance Companies from "discriminating against any provider who is located within the geographic coverage area of the health benefit plan . . . ." *See* §§ 304.17A-110(3) and 304.17A-171. The AWP laws would clearly apply to HMOs, HSCs, or Insurance Companies providing plan administration services, as there is nothing in the statute that would exclude them in such a scenario.

Although HMOs, HSCs, and Insurance Companies may accept risk in some situations, as third party administrators they would merely be contracting to handle paperwork and plan administration for a self-insured ERISA plan. While handling such administrative duties, however, these entities would be forced by Kentucky's AWP laws to accept any willing provider into the plan, even though they were not underwriting any risk. The law in this instance is not directed at the business of insurance, as no insurance is involved. *See Prudential Ins. Co.*, 154 F.3d at 829 (observing that the Arkansas AWP statute at issue defined health benefit plans so broadly as to include plan administrators and thus did not fit

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wise unchanged. Section 304.17A-005 defines "Insurer," as used in § 304.17A-270, as:

> [A]ny insurance company; health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider sponsored integrated health delivery network; self-insured employer organized association, or nonprofit hospital medical-surgical, dental, or health service corporation authorized to transact health insurance business in Kentucky.

Ky. Rev. Stat. Ann. § 304.17A-005 (Banks-Baldwin 1999). This definition largely tracks repealed § 304.17A-100(4)(a)'s definition of "Health Benefit Plan." Despite the majority's claim that the substitution of the term "Health Insurer" for "Health Benefit Plan" in the current statute excludes administrators under contract with benefits plans from the scope of the statutes, the definition of "insurer" continues to include plan administrators.

within a common sense view of a law directed specifically toward the insurance industry); *Texas Pharmacy Ass'n v. Prudential Ins. Co. of America*, 105 F.3d 1035, 1039 (5th Cir. 1997) (noting that a self-insured employer would not be subject to Texas' AWP statute, "but if the employer signed up with an HMO or PPO, those organizations would be subject to the statute, even if there is no insurance involved"); *Cigna Health Plan of La., Inc.* 82 F.3d at 649 (concluding that Louisiana's AWP law was obviously not limited to entities within the insurance industry, in part because it applied to "health care financiers, third party administrators, providers, or other intermediaries"). The only risk underwritten is that accepted by the ERISA self-insured plan, which under the "deemer clause" of ERISA § 514 (b)(2)(B), 29 U.S.C. § 1144(b)(2)(B), cannot be treated as an insurance company for the purposes of state regulation. *See FMC Corp. v. Holliday*, 498 U.S. 52, 61, 111 S. Ct. 403, 409, 112 L. Ed. 2d 356 (1990); *Texas Pharmacy Ass'n*, 105 F.3d at 1039. The common sense conclusion that can be drawn from the AWP statute's coverage of entities clearly operating outside of the business of insurance is that the statute is concerned generally with regulating provider access to networks rather than specifically regulating the business of insurance.[6] *See Prudential Ins. Co.*, 154 F.3d at 829 (concluding that the AWP law at issue was "not a law directed at the insurance industry at all, but a law directed at regulation of broadly defined health benefit plans, only some of which fall within the insurance industry").

The majority seeks to refute this conclusion by arguing that Kentucky's AWP law would not apply to entities performing only plan administration for self insurers, apparently on the grounds that to the extent that Kentucky's AWP law

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[6] The fact that §§ 304.17A-110(3) and 304.17A-171(2) happen to be codified amongst Kentucky's insurance provisions does not alter this conclusion, as it in no way assures that the law is specifically directed toward the insurance industry.

seeks to do so, they would be preempted by ERISA. In support the majority cites *Light v. Blue Cross and Blue Shield of Alabama, Inc.*, 790 F.2d 1247, 1248 (5th Cir.1986), which holds that state laws which apply to administrators of self insured plans may be preempted by ERISA and "if ERISA preempts state law, there is no applicable state law to which the administrator must conform." Other courts have drawn a similarly unremarkable conclusion. *See Insurance Bd. Under Social Ins. Plan of Bethlehem Steel Corp. v. Muir*, 819 F.2d 408, 410-13 (3d Cir. 1987) (concluding that Blue Cross and Blue Shield, which provided plan administration services for a self-insured employee benefit plan, were not engaged in the business of insurance and therefore that the state mandated benefit laws were preempted with respect to not only the underlying self-insured plan, but also the plan administrators).

Light, however, is inapposite to the proposition the majority ultimately seeks to advance, that is, if Kentucky's AWP law does not apply to self-insurers, *a fortiori*, it also does not apply to entities administering the self-insured plan. The employee benefit plan at issue in *Light* contained a provision stating that "the contracts between South Central Bell and the plan administrator necessarily will conform to applicable state laws." 790 F.2d at 1248. Plaintiffs argued that since the plan adopted state law, the plan administrator was required to comply with that law. The Fifth Circuit began by noting that if ERISA preempted state law, there would be no state law for the administrator to conform to. The court then turned to Plaintiffs' argument that the preemption provision of 29 U.S.C. § 1144 (a) should not be read to apply to plan administrators. Plaintiffs asserted that because their action was against a plan administrator, it did not relate to an employee benefit plan, and therefore was not preempted. The court found no merit in plaintiffs' argument because, "absent ERISA the state common law on which [plaintiffs] rely would provide causes of action for the improper handling of claims under benefit plans," giving the law a "direct connection" with employee benefit plans. *Id.* at 1249. As a consequence,

the court found § 1144 preempted plaintiffs' state causes of action with respect to the administrator of their self-insured plan as well. *Id.*

In the case at bar, the majority states that based in part on reliance on *Light*, it does not believe that Kentucky's AWP law could be enforced against plan administrators of self-insured plans. The majority appears to arrive at this conclusion due to its belief that, as in *Light*, Kentucky's AWP statute would be preempted insofar as it applies to plan administrators, given that Kentucky's AWP statute "relates to" employee benefit plans. However, having concluded that the *entire* AWP provision is preempted, the majority fails to apply savings clause analysis to the *entire* AWP provision. As I have discussed, Kentucky's law, by its very terms, does attempt to regulate entities outside the insurance industry, through its regulation of HMO and HSC and Insurance Company contracts, which would include contracts purely for plan administration. The majority attempts to ignore this fact by summarily concluding that the law would not apply to plan administrators. However, in doing so the majority is apparently saying that the law is clearly preempted and not saved insofar as it applies to plan administrators, and then arguing that due to this preemption, the statute does not apply to entities outside the insurance industry. The majority cites no authority for its attempt to dissect Kentucky's AWP provisions, dismissing some of the provision's applications as preempted and then applying saving clause analysis only to those applications it wishes to retain. In applying the common sense test we should be looking at the whole provision, not determining whether portions of a provision are saved in some, but not all scenarios.

In sum, unlike *Ward*, where the notice-prejudice rule was by its very terms "directed specifically at the insurance industry and [was] applicable only to insurance contracts," 119 S. Ct. at 1386, Kentucky's AWP laws clearly apply to entities

and contracts outside the insurance industry.[7] As a result, I must conclude that §§ 304.17A-110(3) and 304.17A-171(2) do not "satisfy the commonsense view as . . . regulations that hone in on the insurance industry" but rather the provisions "just have an impact on [that] industry." *See Ward*, 119 S. Ct. at 1387 (quoting *Pilot Life*, 481 U.S. at 50, 107 S. Ct. at 1554).

B.

Next I "consider [the] three factors employed to determine whether the regulation fits within the 'business of insurance' as that phrase is used in the McCarran-Ferguson Act: first whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry." *Ward*, 119 S. Ct. at 1386 (in-

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[7] In an attempt to dismiss the problem of partial preemption (insofar as applied only to plan administrators), the majority appears to draw a distinction between Kentucky's AWP statute and the AWP statute at issue in *Prudential Ins. Co.*, on the grounds that Kentucky's statute does not specifically state that it applies to "plan administrators." However, §§ 304.17A-110(3) and 304.17A-171(2) apply to "Health Benefit Plans," defined to include HMO and HSC contracts. Similarly, § 304.17A-270 applies to "Health Insurers," defined to include all Insurance Companies, HMOs and HSCs. These definitions in no way limit the applicability of Kentucky's AWP provisions to entities underwriting risk. Consequently, if a self-insurer entered into a contract with an HMO, HSC, or Insurance Company solely for the provision of plan administration, there is no reason that the AWP laws would not apply. A plain reading of the AWP provision compels this conclusion regardless of the law's applicability to the self-insured entity the HMO or HSC contracted with. Consequently, one can only conclude that the AWP provisions are preempted, as by their terms they apply directly to HMO's and HSC's that have merely agreed to operate as administrators of self-insured employee benefit plans.

ternal citations and quotations omitted). The McCarran-Ferguson factors only serve to reinforce my conclusion that Kentucky's AWP laws are not saved from preemption by ERISA § 514(b). While none of the McCarran-Ferguson factors should be seen as dispositive, they provide helpful guideposts for savings clause analysis, lending depth and guidance to the common sense test, particularly in difficult cases such as the one we are presented with. *See Ward* 119 S. Ct. at 1389. With this understanding I begin by considering whether Kentucky's AWP laws have the effect of transferring or spreading policyholder risk.

Appellees argue, and the majority agrees, that the district court was correct in finding that Kentucky's AWP laws spread policyholder risk. The district court reached this conclusion because it believed the laws were similar to the mandated benefit laws that the Supreme Court found to spread risk in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 85 L. Ed. 2d 728, 105 S. Ct. 2380 (1985). According to the district court, risk was spread because Kentucky's AWP laws made it more likely that an insurer would cover a visit to a provider that the policyholder may have paid to visit on his or her own, due to the policyholder's preference for that particular provider.

I disagree with the district court's attenuated risk spreading analysis and find its analogy to *Metropolitan Life* to be misplaced. *Metropolitan Life* involved a Massachusetts law which required insurers to provide certain minimum mental health benefits to Massachusetts residents. *Id.* at 724, 105 S. Ct. 2380. While applying the McCarran-Ferguson factors to the Massachusetts law, the Supreme Court concluded that risk was being spread because the statute was intended "to effectuate the legislative judgment that the risk of mental-health care should be shared." *Id.* at 743, 105 S. Ct. 2391.

Mandated benefit laws like the one at issue in *Metropolitan Life* require an insurer to treat individuals with health care conditions that may not have been covered before the law.

The effect of such laws is to shift a significant degree of risk from individuals who originally had no such coverage under the insurance policy, to the insurer. Although a closer question, the same can likely be said for mandated provider laws. Under such laws, an insurance company must provide coverage for treatment from any category of provider,[8] which typically broadens insurance coverage to include forms of alternative medicine (e.g., chiropractic, massage therapy, acupuncture) not previously covered under the policy. The Ninth Circuit confronted such a law in *Washington Physicians Serv. Ass'n v. Gregoire*, 147 F.3d 1039 (1998). In analyzing whether the law fell under the savings clause as a law regulating insurance, the court began by recognizing that:

> Because insurance is the business of spreading risk, Royal Drug, 440 U.S. at 205, 99 S. Ct. 1067, a state law that regulates the relationship between a carrier and a provider without affecting the risk borne by the insured is outside the definition of insurance regulation. Id. at 213-214, 99 S. Ct. 1067; Hahn v. Oregon Physicians Serv., 689 F.2d 840, 843-844 (9th Cir. 1982).

147 F.3d at 1045. The court concluded, however, that by expanding the kinds of treatment that an insurer must cover to include various types of alternative medicine, the risk that the insured might need alternative medical treatment was shifted to the insurance company. *See Gregoire*, 147 F.3d at 1046. In reaching this conclusion, the court distinguished Washington's mandatory provider law from AWP laws, noting that the mandatory provider statute did not require any carrier to contract or deal with any particular provider; instead it merely

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[8] The insurance company's ability to use limited provided networks remains unaffected by such a law.

forbade a carrier from excluding a particular class of provider. *See Gregoire* 147 F.3d at 1046.[9]

AWP statutes such as Kentucky's are different in purpose and effect than either the mandatory benefit or mandatory provider statutes respectively at issue in *Metropolitan Life* and *Gregoire*. Rather than shifting risk from policyholders to insurers, Kentucky's AWP statutes merely prohibit benefit plans from excluding qualified providers who want to join the plan's provider network and are able to meet the plan's requirements. The risk assumed by the benefit plan under its policy, that the policyholder will require medical treatment, remains unaltered. The statute's passage in no way alters the terms of the policyholder's policies.[10] The only contracts affected are those between the benefit plan and the providers already in the plan network. Kentucky's AWP laws do not require that a single doctor be added to any benefit plan network; benefit plans may still maintain provider networks which require doctors to meet certain terms before joining and the plans may still require that policyholders see plan doctors for their medical costs to be covered. *See* Gary A. Francesconi, *Erisa Preemption of "Any Willing Provider" Laws-An Essential Step Toward National Health Care Reform*, 73 Wash. U. L.Q. 227, 248-49 (1995) (observing that

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[9] As to the issue of whether AWP laws spread risk, the *Gregoire* court stated that it expressed no opinion. *Gregoire*, 147 F.3d at 1047.

[10] The majority mysteriously concludes that the provision changes the policy between the insured and insurer, "not in terms of covered medical conditions, but in terms of covered treatment by health care providers." However, both the medical risks and corresponding treatment covered by the insurer remain unaltered by Kentucky's AWP law. Consequently, I assume that by this statement the majority really means that by potentially expanding the number of plan doctors that one could go to receive treatment for a covered condition, the AWP law somehow changes the contract between the insurer and insured.

with or without the any willing provider law, the insured's access to certain providers is limited by the policy).

While doctors who meet the plans qualifications may independently decide to join the plan and the plan must accept them, many doctors may not meet the plan's qualifications or may have no desire to join that particular plan. For example, in an area with multiple benefit plans, a relatively small percentage of additional qualified doctors may decide to join any particular plan network. In such a scenario, many doctors may already be members of several plan networks and may have no desire to enroll in additional networks. Even those qualified doctors who were previously excluded from all the plans in such an area would be unlikely to join every plan after the AWP law. The result is that although Kentucky's AWP laws make it marginally more likely that a policyholder's benefit plan network will contain their preferred doctor,[11] they will still be restricted to the doctors in their benefit plan network regardless of the membership or nonmembership of their preferred doctor.

The Supreme Court discussed the transfer of policyholder risk in detail in *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 99 S. Ct. 1067, 59 L. Ed. 2d 261 (1979). The Court was considering whether agreements between Blue Shield and participating pharmacies concerning the price that policyholders would pay for prescriptions, constituted the business of insurance. Under the agreements, the participating pharmacies would fill any Blue Shield policyholder's prescription for a two-dollar charge. *See id.* at 209, 99 S. Ct. at 1072. The pharmacy was then entitled to reimbursement from Blue Shield for the cost of acquiring the drugs prescribed. *See id.* The Court found that, under the antitrust exemption provision of the McCarran-Ferguson Act,

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[11] If their doctor met the plans qualifications, had wanted to join the plan, but was denied membership, that doctor could no longer be kept out of the network if he or she still wished to join.

15 U.S.C. § 1012(b), the arrangement did not constitute the "business of insurance" because Blue Shield's agreement with the pharmacies merely limited the *amount* that it would have to pay to cover its policyholder risks. *See id.* at 214-15, 99 S. Ct. at 1075. While realizing that the policyholders might ultimately benefit in the form of lower rates charged by Blue Shield, the Court concluded that no additional policyholder risks were being underwritten. Instead, the Court saw the agreements as merely arrangements for the purchase of goods and services by Blue Shield and thus not the "business of insurance." *See id.* at 214, 99 S. Ct. at 1075.

The majority attempts to distinguish *Royal Drug* on the grounds that "[u]nlike the health plans that are the subject of the Kentucky statute, the insurer in Royal Drug did not restrict the number of providers in question." However, the insurer in *Royal Drug* merely *offered* to enter into agreements with each licensed pharmacy in Texas. This is significantly different from actually entering into such agreements, because, as the Supreme Court observed, "only pharmacies that can afford to distribute prescription drugs for less than this $2 markup can profitably participate in the plan." *Id.* at 209, 99 S. Ct. at 1072. As a result, the insurer's promise to enter into agreements with all pharmacies was essentially an empty one, as only larger, high volume pharmacies could afford to enter into such an agreement. Such a hollow offer provides no real basis to distinguish the case from the limited provider networks at issue in the case at bar.

Similarly, Kentucky's AWP laws have almost no effect on the policyholder risk that insurers must underwrite. Like Blue Shield's unchanged obligation to cover a policyholder's prescriptions after entering into the pharmacy agreements, Kentucky insurers must cover the same medical procedures after the AWP law as they would have to if the AWP provision had not been enacted. It is true that the AWP laws would likely force insurers to pay higher rates, however, as in *Royal Drug*, this would only affect the price that insurers must pay

for procedures covered in the policies they have issued, not the type of policyholder risks that they contractually must cover.[12] *Accord, Prudential Ins. Co.*, 154 F.3d at 828 (finding that the Arkansas AWP statute plainly did not spread risk, and noting that appellants did not even attempt to argue to the contrary).

In discussing the nature of insurance, the *Royal Drug* Court referred to *SEC v. Variable Annuity Life Ins. Co.*, 359 U.S. 65, 79 S. Ct. 618, 3 L. Ed. 2d 640 (1959), quoting it for the proposition that "the concept of insurance involves some investment risk-taking on the part of the company." The Court noted that while petitioners didn't dispute this fact, they maintained that the pharmacy agreements did involve the underwriting of risk. To this end, they argued that Blue Shield accepted a premium and assumed the risk that policyholders would need prescription drugs by agreeing to enter into contracts with existing pharmacies to provide such drugs for promised reimbursement from Blue Shield. The Court observed that "the fallacy of petitioner's position is that they confuse the obligations of Blue Shield under its insurance policies, which insure against the risk that the policyholders will be unable to pay for prescription drugs during the period of coverage, and the agreements between Blue Shield and the participating pharmacies, which serve only to minimize the

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[12] Under Kentucky's AWP law, benefit plans can no longer guarantee a limited panel of providers to which other doctors will not be added to handle the plan's patients. To the extent that contracts between benefit plans and providers contained such exclusivity provisions, under the majority's holding they will no longer be enforceable. While the likely result is an increase in the price that insurers must pay, this is not because of an increase in risk, but rather it is due to a decrease in the volume discount an insurer can command if policyholders are spread across a potentially larger network of plan doctors. *See Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 213-15, 99 S. Ct. 1067, 1074-76, 59 L. Ed. 2d 261 (1979).

costs Blue Shield incurs in fulfilling its underwriting obligations." The court then noted that the benefit promised to the policyholders, that they would only have a two-dollar co-payment for any prescriptions, remained unchanged by the arrangement.

As a result the court concluded that Blue Shield's arrangements left policyholders basically unconcerned (from a financial perspective) about the arrangements Blue Shield entered into with participating pharmacies. This is not to say that at least some participants would not be disappointed by the fact that their pharmacy of choice might not have been included, if for example it was not large enough to provide prescriptions for only a two-dollar markup. However, the *financial risks* that Blue Shield agreed to cover remained unchanged, leaving the policyholders without concern for Blue Shield's cost savings agreements with the larger pharmacies.

As the majority notes, in the case at bar the policyholders were also unconcerned with the insurer's compensation arrangements. However, the majority concludes that the policyholders were concerned with restrictions on their freedom of choice in seeking medical treatment. Ignoring for a moment the fact that Kentucky's AWP laws do not allow policyholders the freedom to choose their own doctor, and thus only addresses this concern in at best a very tangential way, any concerns over freedom of choice are beside the point. The critical issue with respect to the risk spreading prong, as well as whether the law regulates insurance as a matter of common sense, is whether or not the law is related to the risks underwritten by the insurer. As the Court noted in *Royal Drug*, while discussing the meaning of "business of insurance" under the McCarran-Ferguson Act: "It is important, therefore, to observe at the outset that the statutory language in question here does not except the business of insurance companies from the scope of the antitrust laws. The exemption is for the 'business of insurance,' not the 'business of insurers.'" 440 U.S. at 210-11, 99 S. Ct. at 1073. Because Kentucky's AWP

laws seek to merely regulate the "business of insurers" by dictating how they structure their provider networks, irrespective of the risks they underwrite, they should not qualify for savings clause protection.

The majority points to *Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir. 1993), as support for its contention that Kentucky's AWP laws do transfer risk. *Stuart Circle* involved a Virginia statute which required insurers to accept any willing provider if they established preferred provider networks. The court concluded that while the statute "related to" ERISA plans, it was not preempted, because it fell within ERISA's savings clause as a law regulating insurance. *Id.* at 504. After finding the common sense test satisfied, in part because the law was located within Virginia's insurance code,[13] the court moved on to the McCarran-Ferguson factors. Discussing whether the law transferred or spread policyholder risk, the court concluded that the Virginia statute "affects the type and cost of treatment available to an insured." *Id.* The court reached this conclusion because it believed that without the AWP law, policyholders might on occasion attend a doctor outside of their plan network, due to

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[13] As indicated above, this fact should have little to do with determining whether a law is specifically directed at the insurance industry, as any law may be inserted within the insurance provisions of a state code. Further, the Virginia statute at issue, § 38.2-3407, only applied to "insurers," defined within the Chapter to mean "an insurance company" which is itself defined as "any company engaged in the business of making contracts of insurance." Va. Code Ann. § 38.2-100. Thus, Virginia's AWP statute was more narrow in scope than Kentucky's, quite specifically limiting its application to the term "insurance companies," defined by the statute to include only companies actively issuing insurance contracts. Consequently, Virginia's statute would clearly not apply to entities engaged in only administrative functions for an employee benefit plan.

a personal preference for that doctor, and in doing so, would be forced to shoulder all or part of the cost. *See id.*

I am unpersuaded by the majority's argument that *Stuart Circle*'s attenuated risk spreading rationale should be applied to Kentucky's AWP laws. As I have discussed, Kentucky's AWP laws do not require health benefit plans to include a single additional provider unless the qualified provider, not the policyholder, decides to join the plan. Policyholders are not necessarily any better off than they were before the law was passed, only benefitting from the law if their provider is both willing to join their particular provider network and able to meet its requirements. The insurance policy and the contingencies it underwrites, *i.e.*, the risk that insured will need medical treatment for a condition covered under the policy, remain the same, regardless of Kentucky's AWP law.[14]

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[14] The conclusion that Kentucky's AWP laws are not the business of insurance is supported by the following rhetorical question which the Supreme Court posed in *Royal Drug*. The court addressed a scenario which essentially involved limited provider networks, stating:

> Suppose, for example, that an insurance company entered into a contract with a large retail drug chain whereby its policyholders could obtain drugs under their policies only from stores operated by this chain. The justification for such an agreement would be administrative and bulk-purchase savings resulting from obtaining all of the company's drug needs form a single dealer. Even though these cost savings might ultimately be reflected in lower premiums to policyholders, would such a contract be the "business of insurance?" Or suppose that the insurance company should decide to acquire the chain of drug stores in order to lower still further its costs of meeting its obligations to its policyholders. Such an acquisition would surely not be the "business of insurance."

There is no shifting of the risk between the policyholder and insurer that a specific medical contingency will occur.

The majority attempts to escape from *Royal Drug*'s teaching by relying on dicta from *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F. Supp. 60 (D. Mass. 1997), in which the court questioned "whether the holding of *Royal Drug* may be translated into the ERISA pre-emption context at all." *Id.* at 72. The *American Drug Store* court was referring to the fact that *Royal Drug* interpreted the scope of the antitrust exemption under § 2(b) of the McCarran-Ferguson Act, but did not address §§ 1 and 2(a) of the act, which preserved a State's ability to regulate the "business of insurance" from Commerce Clause attack. *See Royal Drug*, 440 U.S. at 219 n.18, 99 S. Ct. at 1077.[15] However, the Supreme Court has not indicated that it is troubled by this distinction. As recently as last term, the Court employed the McCarran-Ferguson factors it created in *Royal Drug* and imported into ERISA preemption analysis in *Metropolitan Life*, without any indication that its past precedent interpreting whether a law "regulates insurance" under ERISA's savings clause was called into doubt. *See Ward*, 526 U.S. 358, 119 S. Ct. 1380, 1388, 143 L. Ed. 2d 462 (1999).[16] Until the Court

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440 U.S. at 215, 99 S. Ct. at 1075. If such agreements are not the "business of insurance," then it follows that a state's attempts to regulate these agreements would not qualify as such either.

[15] The majority appears to be persuaded by this reasoning. I do not draw the same conclusion. However, even if the meaning of "business of insurance" was broadened beyond the contractual relationship between the policyholder and insurer, I do not believe that Kentucky's AWP law would qualify. As I have explained elsewhere, Kentucky's AWP laws have at most a speculative and tangential effect on this relationship.

[16] The district court in *Community Health Partners v. Commonwealth of Kentucky*, 14 F. Supp. 2d 991 (W.D. Ky. 1998) observed that *United States v. Fabe*, 508 U.S. 491, 113 S. Ct. 2202, 124 L. Ed. 2d 449 (1993) might be argued to change and broaden

indicates that its *Royal Drug* business of insurance test is no longer appropriate in the ERISA savings clause context, something that it has yet to do, I believe we must continue to apply the test as dictated by the Court's precedent.

Moving to the second McCarran-Ferguson factor, I consider whether Kentucky's AWP laws affect an integral part of the policy relationship between the insurer and insured. The majority asserts that the district court was correct in finding that Kentucky's AWP laws dictate a substantive term of the contract between the insurer and insured and are thus an integral part of this relationship. As support for this proposition, the majority again cites *Stuart Circle*, which concluded that because Virginia's AWP law affected treatment and cost (through the same attenuated manner in which the court concluded risk was spread) it was integral to the insurer-insured relationship. 995 F.2d 500 at 503.

Again I find *Stuart Circle* unconvincing. The effect of Kentucky's AWP laws center on the insurer-provider relationship. The terms of the insurer-insured relationship are only affected in a very indirect manner, making it difficult to see the AWP laws as integral to that relationship. *See Prudential Ins. Co.*, 154 F.3d at 830 (finding the Arkansas AWP law not to be integral to the insurer-insured relationship, as it defined only the terms between the insurer and providers, and distinguishing *Gregoire* because Washington's any category of provider law *did* affect the insurer-insured relationship by expanding the kinds of treatment the policy must cover); *Cf., Pilot Life Co. v. Dedeaux*, 481 U.S. 41, 50-51, 107 S. Ct. 1549, 1554-55, 95 L. Ed. 2d 39 (1987) (noting that Missis-

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savings clause analysis in the ERISA context. However, other federal courts have not reached this conclusion and the Supreme Courts most recent opinion in *Ward* gives no indication that the Court's savings clause analysis has changed. *See also, Prudential Ins. Co.*, 154 F.3d at 827-828 (concluding that *Fabe* had no effect on savings clause analysis).

sippi's law of bad faith, in contrast to the mandated benefits law in Metropolitan Life, did not define the terms between the insurer and insured, and thus only affected the insurer-insured relationship in an attenuated way). The Court's discussion of California's notice-prejudice rule in *Unum Life Ins. Co. of America v. Ward*, 119 S. Ct. at 1389-90 (1999), provides an illuminating example of what qualifies as an integral policy relationship under the McCarran-Ferguson factors. The Supreme Court observed that:

> [California's notice-prejudice rule] serves as an integral part of the policy relationship between the insurer and insured. *Metropolitan Life*, 471 U.S. at 743, 105 S. Ct. 2380. California's rule changes the bargain between insurer and insured; it effectively creates a mandatory contract term that requires the insurer to prove prejudice before enforcing a timeliness-of-claim provision.

Id. In sharp contrast, Kentucky's AWP provisions leave the contract terms between the insurer and insured, unaltered. The relationships directly affected by the law are those existing between insurers and third parties (*i.e.*, medical providers). As discussed above, the medical risks covered by the policy remain the same. Thus, even if an insured's preferred provider decides to join the insured's network, and complies with its terms in doing so, the medical coverage that the insurer has contracted to underwrite remains unchanged. Unlike the mandated benefit laws at issue in *Metropolitan Life*, the mandated provider law in *Gregoire*, or the mandatory notice-prejudice rule in *Ward*, Kentucky's AWP laws do not force the insurer to offer a benefit to insureds that was not available before the law. Rather, Kentucky's AWP laws merely force insurers to potentially make additional contractual arrangements with providers they might otherwise exclude. The medical conditions covered remain unaffected and the insureds are still limited to the plan's network of providers. Therefore, I must conclude that Kentucky's AWP law is not integral to the insured-insurer relationship.

Finally, I consider whether the Kentucky AWP laws are limited to entities within the insurance industry. As discussed under the common sense test, I do not believe this to be the case. The law not only regulates entities that fall outside the traditional definition of insurer, it also extends to include entities in no way involved in underwriting risks. In fact, a review of the statute shows that while it may affect the way that some insurance companies run their business, it has nothing to do with the underwriting of risk, the traditional earmark of insurance. *See Royal Drug*, 440 U.S. at 211-12, 99 S. Ct. at 1073-74. Accordingly, I believe that Kentucky's AWP laws fail the third prong of the McCarran-Ferguson test as well.

In sum, I am forced to conclude that §§ 304.17A-110(3) and 304.17A-171(2), Kentucky's AWP laws, are not saved from preemption as laws that regulate the business of insurance, because under ERISA § 514(b), they fail to meet not only the common sense test, but also all of the McCarran-Ferguson factors.[17] While federalism concerns prohibit federal courts from lightly preempting acts of a state legislature, I agree with the Eighth Circuit's observation in *Prudential Ins. Co.* that, "it is for Congress, not the courts, to reassess ERISA in light of modern insurance practices and the national debate over health care." *Prudential Ins. Co.*, 154 F.3d at 829-30.

II. Severability

Because I believe that Kentucky's AWP provisions, Ky. Rev. Stat. Ann. § 304.17A-110(3) and 304.17A-171(2) (Banks-Baldwin 1995), are preempted by 29 U.S.C. § 1144(a) and not saved by the savings clause of 29 U.S.C. § 1144(b)(2)(A), I write separately to address whether the laws should be invalidated in their entirety, or whether the offending provisions of the statutes may be severed in whole or part.

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[17] As we indicated above, the parties have agreed that our holding with regard to § 304.17A-110(3) will serve to determine whether § 304.17A-270 is preempted as well.

While never explicitly stating so, as discussed above, the majority appears to agree that Kentucky's AWP laws are preempted at least in their application to HMOs and HSCs who are performing administrative or related duties for self-insured employee benefit plans. However, despite implicitly drawing this conclusion, the majority still concludes that the AWP law is saved by the insurance savings clause. In doing so, the majority fails to mention, let alone discuss, how it severs Kentucky's AWP provision in such a manner that it no longer applies to third party plan administrators performing administrative functions for self-insured plans, thereby allowing it to conclude that the provision is saved in all other applications.

The Supreme Court has often stated that the inquiry into whether a statute is severable is essentially an inquiry into legislative intent. *See, e.g., Minnesota v. Mille Lacs Band of Chippewa Indians*, 526 U.S. 172, 119 S. Ct. 1187, 143 L. Ed. 2d 270 (1999); *Zobel v. Williams*, 457 U.S. 55, 64, 102 S. Ct. 2309, 2315, 72 L. Ed. 2d 672 (1982); *Regan v. Time, Inc.*, 468 U.S. 641, 653, 104 S. Ct. 3262, 3269, 82 L. Ed. 2d 487 (1984) (plurality opinion). In discerning the legislature's intent, the Court has directed that:

> Unless it is evident that the legislature would not have enacted those provisions which are within its power, independently of that which is not, the invalid part may be dropped if what is left is fully operative as a law. *Champlin Refining Co. v. Corporation Comm'n of Okla.*, 286 U.S. 210, 234, 52 S. Ct. 559, 76 L. Ed. 1062 (1932). *See also Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684, 107 S. Ct. 1476, 94 L. Ed. 2d 661 (1987); *Regan v. Time, Inc., supra*, at 653, 104 S. Ct. 3262.

Mille Lacs Band of Chippewa Indians, 119 S. Ct. at 1198. Therefore, as evidence of the legislature's intent I look to Kentucky's severability statute, which states:

> It shall be considered that it is the intent of the general assembly in enacting any statute, that if any part of the statute be held unconstitutional the remaining parts shall remain in force, unless the statute provides otherwise, or unless the remaining parts are so essentially and inseparably connected with and dependent upon the unconstitutional part that it is apparent that the general assembly would not have enacted the remaining parts without the unconstitutional part, or unless the remaining parts, standing alone, are incomplete and incapable of being executed in accordance with the intent of the general assembly.

Ky. Rev. Stat. Ann. § 446.090. The statute indicates that if any part of a Kentucky statute is found unconstitutional, it is the legislature's intent that the remaining provisions be saved. However, in drafting the statute the legislature also recognized that situations will exist where severing the offending parts cannot be considered as it would make it impossible to carry out the original legislative intent.

I begin my severability inquiry by addressing whether portions of Ky. Rev. Stat. Ann. §§ 304.17A-110(3) and 304.17A-171(2) may be severed in such a way that the provisions would not be preempted in their entirety. Because I believe that §§ 304.17A-110(3) and 304.17A-171(2) contain an impermissible connection with ERISA covered plans, there is no way to save the provisions themselves from preemption by severing particular parts while leaving the rest intact. Even if it were possible to do so, merely removing any prohibited "references to" ERISA plans would not suffice. The Kentucky provisions impermissible "connection with" ERISA plans would continue, as ERISA plans would still be effectively prohibited from offering limited provider panels, as none would be available to them. The only way that §§ 304.17A-110(3) and 304.17A-171(2) could be saved, would be to add language effectively allowing health care entities to offer limited provider networks to ERISA covered plans. Be-

cause both Kentucky and federal case law prohibit us from adding language to a state statute to remove its conflict with federal law, see, e.g., *Musselman v. Commonwealth*, 705 S.W.2d 476, 477 (Ky. 1986), *Eubanks v. Wilkinson*, 937 F.2d 1118, 1120 (6th Cir. 1991), I conclude that §§ 304.17A-110(3) and 304.17A-171(2) are preempted in their entirety. *See Prudential Ins. Co.*, 154 F.3d at 832 (concluding that the AWP statute at issue was preempted in its entirety); *Texas Pharmacy Ass'n*, 105 F.3d at 1039 (drawing the same conclusion).

Finally, I address whether the preempted provisions, provision (3) of § 304.17A-110 and provision (2) of § 304.17A-171, may be severed from their respective statutory sections or whether the sections must also be preempted. Kentucky's severability statute indicates that unconstitutional provisions may presumptively be severed, unless severing the offending provisions makes it impossible to execute the remaining provisions of a statute in the manner the legislature intended. It is clear that §§ 304.17A-110 and 304.17A-171 can be executed in accordance with the legislature's original intention without provision (3) and (2) respectively. Accordingly, while I conclude that §§ 304.17A-110(3) and 304.17A-171(2) should be preempted in their entirety, the statutory sections they reside in should remain unaffected.

FTC Letter of Feb. 4, 1993 to Attorney General of Montana Regarding "Any Willing Provider" Law

The Honorable Joseph P. Mazurek
Attorney General of the State of Montana
Justice Building
Helena, MT 59620

Dear Mr. Attorney General:

The staff of the Federal Trade Commission[1] is pleased to submit this response to your request for views on the possible competitive effects of maintaining in place the recently-enacted "any willing provider" law, which is set to sunset in July 1993. This law limits the ability of preferred provider organizations ("PPOs") to arrange for services through contracts with health care providers, by requiring a PPO to enter a contract with any provider willing to meet the terms the PPO sets. By preventing PPOs from limiting the panel of providers, the law discourages contracts with providers in which lower prices are offered in exchange for the assurance of higher volume. Although the law may be intended to assure consumers greater freedom to choose where they obtain services, it appears likely to have the unintended effect of denying consumers the advantages of cost-reducing arrangements and limiting their choices in the provision of health care services.

I. Interest and experience of the Federal Trade Commission.

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[1] These comments are the views of the staff of the Federal Trade Commission, and do not necessarily represent the views of the Commission or any individual Commissioner.

The Federal Trade Commission is empowered to prevent unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[2] Pursuant to this statutory mandate, the Commission encourages competition in the licensed professions, including the health care professions, to the maximum extent compatible with other state and federal goals. For several years, the Commission and its staff have investigated the competitive effects of restrictions on the business practices of hospitals and state-licensed health care professionals.

The Commission has observed that competition among third-party payors and health care providers can enhance the choice and availability of services for consumers and can reduce health care costs. In particular, the Commission has noted that the use by prepaid health care programs of limited panels of health care providers is an effective means of promoting competition among such providers.[3] The Commission has taken law enforcement action against anti-competitive efforts to suppress or eliminate health care programs, such as health maintenance organizations ("HMOs"), that use selective contracting with a limited panel of health care providers.[4]

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[2] 15 U.S.C §41 *et seq.*

[3] Federal Trade Commission, Statement of Enforcement Policy With Respect to Physician Agreements to Control Medical Prepayment Plans, 46 Fed. Reg. 48982, 48984 (October 5, 1981); Statement of George W. Douglas, Commissioner, On Behalf of the Federal Trade Commission, Before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, United States House of Representatives, on H.R. 2956: The Preferred Provider Health Care Act of 1983 at 2-3 (October 24, 1983); Health Care Management Associates, 101 F.T.C. 1014, 1016 (1983) (advisory opinion). *See also* Bureau of Economics, Federal Trade Commission, Staff Report on the Health Maintenance Organization and Its Effects on Competition (1977).

[4] *See, e.g.*, Medical Service Corp. of Spokane County, 88 F.T.C. 906 (1976); American Medical Association, 94 F.T.C. 701

The staff of the Commission has submitted, on request, comments to federal and state government bodies about the effects of various regulatory schemes on the competitive operation of such arrangements.[5] Several of these comments have addressed "any willing provider" requirements for health care service contracts.[6]

(1979), aff'd as modified, 638 F.2d. 443 (2d Cir. 1980), aff'd by an equally divided court, 455 U.S. 676(1982); Forbes Health System Medical Staff, 94 F.T.C. 1042 (1979); Medical Staff of Doctors' Hospital of Prince George's County, 110 F.T.C. 476 (1988); Eugene M. Addison, M.D., III F.T.C. 339 (1988); *Medical Staff of Holy Cross Hospital, No.* C-3345 (consent order, Sept 10, 1991); *Medical Staff of Broward General Medical Center,* No. C-3344 (consent order, Sept. 10, 1991); *see also* American Society of Anesthesiologists, 93 F.T.C. 101 (1979); Sherman A. Hope, M.D., 98 F.T.C. 58 (1981).

[5] The staff of the Commission has commented on a prohibition of exclusive provider contracts between HMOs and physicians, noting that the prohibition could be expected to hamper procompetitive and beneficial activities of HMOs and deny consumers the improved services that such competition would stimulate. *See, e.g.,* Letter from Bureau of Competition to David A. Gates, Commissioner of Insurance, State of Nevada (November 5, 1986).

[6] The staff submitted comments to the Massachusetts House of Representatives concerning legislation that would have required prepaid health care programs to contract with all pharmacy suppliers on the same terms (or offer subscribers the alternative of using any pharmacy they might choose), noting that the bill might reduce competition in both pharmaceutical services and prepaid health care programs, raise costs to consumers, and restrict consumers' freedom to choose health care programs. Letter from Bureau of Competition to Representative John C. Bartley (May 30, 1989, commenting on S.B. 526). The staff has submitted similar comments on similar legislation in Pennsylvania, New Hampshire, and California. Letter from Cleveland Regional Office to Senator H. Craig Lewis (June 29, 1990, commenting on S.B. 675); letter from Office of Consumer and Competition Advocacy to Paul J. Alfano (March 17,1992, commenting on H.B. 470); letter from Office of Con-

II. Description of Montana's "Any Willing Provider" Law.

Montana law permits "preferred provider" agreements between providers of health care services and health care insurers relating to the amounts charged and the payments to the providers.[7] The law apparently extends to agreements with all kinds of health care providers: hospitals, professional practitioners, pharmacies, and other providers of health care services.

The "any willing provider" requirement is a temporary provision, which was adopted in 1991. It requires that an insurer establish terms and conditions to be met by providers wishing to enter such agreements.[8] Any provider willing to meet those terms and conditions must be permitted to enter an agreement with the insurer that set them. This "any willing provider" requirement is set to terminate July 1, 1993. At that time, unless the requirement is extended by legislative action, the PPO law will explicitly deny that an insurer must negotiate or enter into agreements with any specific provider or class of providers.[9]

This comment will focus on how "any willing provider" requirements limit contracting between providers and third-party payors, and on how this limitation is likely to affect competition and consumers. The actual effects of Montana's law may be difficult to gauge, because it has been in effect

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sumer and Competition Advocacy to The Honorable Patrick Johnston (June 26, 1992, commenting on S.B. 1986).

[7] Mont. Code Ann., Title 33, Ch. 22, Part 17 (1991).

[8] Mont. Code Ann. § 33-22-1704 (Temporary). These terms and conditions may not be discriminatory; however, the law permits differences among geographic regions or specialties, or differences among institutional providers, such as hospitals, that result from individual negotiation.

[9] Mont. Code Ann. §33-22-1704(3).

only for a short time. The expectation that the requirement would end soon may have affected how providers and PPOs have dealt with each other. Thus, this comment is based on general principles, rather than Montana's particular experience.

III. Competitive importance of programs using limited-provider panels.

Over the last twenty years, financing and delivery programs that provide health care services through a limited panel of health care providers have proliferated, in response to increasing demand for ways to moderate the rising costs associated with traditional fee-for-service health care. These programs may provide services directly or arrange for others to provide them. The programs, which include HMOs and PPOs, typically involve contractual agreements between the payor and the participating health care providers. Many sources now offer limited-panel programs. Even commercial insurers, which in the past did not usually contract with providers, and Blue Cross or Blue Shield plans, which do not usually limit severely the number of providers who participate in their programs, now frequently also offer programs that do limit provider participation.

The popular success of programs that limit provider participation appears to be due largely to their perceived ability to help control costs. Economic studies have confirmed that, under health care arrangements that permit selective contracting, competition helps to moderate cost increases.[10] In

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[10] Studies have examined the competitive effects of selective contracting, in particular California's experience with permitting hospitals to contract selectively. *See, e.g.*, J. C. Robinson and C. S. Phibbs, *An Evaluation of Medicaid Selective Contracting in California*, 8 J. Health Econ. 437 (1989). This study found that shifting from cost-reimbursement to permitting selective contracting moderated increases in hospital costs, particularly in more competitive local markets. This study concentrated on Medicaid experience;

addition, subscribers may benefit from broader product coverage and lower out-of-pocket payments that these cost savings may make possible. Competition among different kinds of third-party payor arrangements, including those that limit provider participation and those that do not, should ensure that cost savings are passed on to consumers. This principle would apply to all types of health care payment programs and health care providers.

Hospitals compete, ultimately, for the business of patients. A hospital may pursue the business of subscribers to PPO or HMO programs by seeking access to those subscribers on a preferential, or even an exclusive, basis. The hospital may perceive several advantages to such arrangements. A preferential or exclusive arrangement may assure the hospital of enough patients to make possible savings from economies of scale, for example, by spreading fixed costs over a larger volume of sales. At a minimum, it could facilitate business planning by making sales volumes more predictable. The arrangement may reduce transaction costs by reducing the number of third-party payors with whom the hospital deals, and may reduce marketing costs that would otherwise be incurred to generate the same business. To get access to the business and the advantages represented by these programs, hospitals compete with each other, offering lower prices and additional services, to get the payors' contracts.

Third-party payors find such arrangements attractive because they benefit from the providers' competition. Lower prices paid to providers could mean lower costs for a third-party payor. Not only might the amounts paid out for services

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however, further studies based on private health insurance experiences confirm these findings. *See, e.g.*, D. Dranove et al., *Is hospital compensation wasteful?* Rand J. Econ., Summer 1992; *see also* G. Melnick et al., The Effects of Market Structure and Bargaining Position on Hospital Prices, 11 J. of Health Economics 217 (Oct. 1992).

be lower, but in addition administrative costs might be lower for a limited-panel program than for one requiring the payor to deal with, and make payments to, all or most of the providers doing business in a program's service area. A payor might find it easier to implement cost-control strategies, such as claims audits and utilization review, if the number of providers whose records must be reviewed is limited. And lower prices and additional services would help make the payor's programs more attractive in the prepaid health care market.

Consumers too may prefer limited-provider programs if the competition among providers leads to lower premiums, lower deductibles, or other advantages. Consumer preference for limited panel programs would presumably mean that, in the consumers' view, these advantages would outweigh the disadvantages of limiting the choice of providers, such as reduced convenience or the occasional need to use a provider that is not part of the payor's contracted service. Limitations on choice are unlikely to be so severe that consumers' access to providers is inadequate. For just as competitive forces encourage providers to offer their best price and service to a payor in order to gain access to its subscribers, competition would also encourage payors to establish service arrangements that offer the level of accessibility that subscribers want. Consumers' ability to change programs or payors if they are dissatisfied with service availability would give payors an incentive to assure that the arrangements they make for delivery of covered health care services satisfy consumers.

IV. Effects of "any willing provider" requirements on limited-panel programs.

"Any willing provider" requirements may limit firms' ability to reduce the cost of delivering health care without providing any substantial public benefit. They may make it more difficult for third-party payors, including PPOs, to offer programs that have the cost savings and other advantages discussed above. Requiring that programs be open to all providers wishing to participate on the same terms may affect both

cost and coverage. To the extent that opening programs to all providers reduces the portion of subscribers' business that each contracting provider can expect to obtain, these providers may be less willing to enter agreements that contemplate lower prices or additional services. Moreover, since any provider would be entitled to contract on the same terms as other providers, there would be little incentive for providers to compete in developing attractive or innovative proposals. Because all other providers can "free ride" on a successful proposal formulation, innovative providers may be unwilling to bear the costs of developing a proposal. Thus "any willing provider" requirements may substantially reduce provider competition for this segment of their business.

Reduced competition among providers for PPO business can result in higher prices for services through PPOs. The higher prices for covered services, as well as the increased administrative costs associated with having to deal with many more providers, may raise the prices to subscribers for pre-paid health care programs, or may force those programs to reduce benefits to avoid raising those prices.

Moreover, requiring programs to be open to more providers may not give the consumer benefits from greater choice. Subscribers may already choose other types of prepayment programs with fewer limits on the providers from which they may obtain covered services. Indeed, by reducing their competitiveness with other kinds of third-party payment programs, requiring PPOs to grant open participation may reduce the number, variety, and quality of prepayment programs available to consumers without providing any additional consumer benefit.

V. Conclusion.

In summary, we believe that "any willing provider" requirements may discourage competition among providers, in turn raising prices to consumers and unnecessarily restricting consumer choice in pre-paid health care programs, without

providing any substantial public benefit. We hope these comments are of assistance.

Sincerely,

Michael O. Wise
Acting Director

RELEVANT STATUTORY PROVISIONS

Kentucky's "Any Willing Provider" statute, Ky. Rev. Stat. Ann. § 304.17A-270, provides:

> A health insurer shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer, including the Kentucky state Medicaid program and Medicaid partnerships.

* * * *

The AWP statute's definitional section, Ky. Rev. Stat. Ann. § 304.17A-005, provides in relevant part:

> As used in this subtitle, unless the context requires otherwise:
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> * * *
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> (18) "Health benefit plan" means any hospital or medical expense policy or certificate; nonprofit hospital, medical-surgical, and health service corporation contract or certificate; provider sponsored integrated health delivery network; a self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA; health maintenance organization contract; or any health benefit plan that affects the rights of a Kentucky insured and bears a reasonable relation to Kentucky, whether delivered or issued for delivery in Kentucky, and does not include policies covering only accident, credit, dental, disability income, fixed indemnity medical expense reimbursement policy, long-term care, Medicare supplement, specified disease, vision care, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment in-

surance, insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance, short-term coverage, student health insurance offered by a Kentucky-licensed insurer under written contract with a university or college whose students it proposes to insure, medical expense reimbursement policies specifically designed to fill gaps in primary coverage, coinsurance, or deductibles and provided under a separate policy, certificate, or contract, or coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code;

(19) "Health care provider" or "provider" means any facility or service required to be licensed pursuant to KRS Chapter 216B, pharmacist as defined pursuant to KRS Chapter 315, and any of the following independent practicing practitioners:

(a) Physicians, osteopaths, and podiatrists licensed under KRS Chapter 311;

(b) Chiropractors licensed under KRS Chapter 312;

(c) Dentists licensed under KRS Chapter 313;

(d) Optometrists licensed under KRS Chapter 320;

(e) Physician assistants regulated under KRS Chapter 311;

(f) Nurse practitioners licensed under KRS Chapter 314; and

(g) Other health care practitioners as determined by the department by administrative regulations promulgated under KRS Chapter 13A;

* * *

(23) "Insurer" means any insurance company; health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider-sponsored integrated

health delivery network; self-insured employer-organized association, or nonprofit hospital, medical-surgical, dental, or health service corporation authorized to transact health insurance business in Kentucky;

* * *

(29) "Provider-sponsored integrated health delivery network" means any provider-sponsored integrated health delivery network created and qualified under KRS 304.17A-300 and KRS 304.17A-310; * * * * .

* * * *

ERISA's preemption provision, 29 U.S.C. § 1144(a), provides:

> Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) [29 U.S.C. § 1003(a)] and not exempt under section 4(b) [29 U.S.C. § 1003(b)].

* * * *

ERISA's savings clause, 29 U.S.C. § 1144(b)(2)(A), provides:

> Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

* * * *

ERISA's deemer clause, 29 U.S.C. § 1144(b)(2)(B), provides:

> Neither an employee benefit plan described in section 4(a) [29 U.S.C. § 1003(a)], which is not exempt under section 4(b) [29 U.S.C. § 1003(b)] (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a

plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.